

HEALTH CARE PLAN
SEVERE ALLERGY TO: _____

Student Name: _____
Birthdate: _____

School: _____

Emergency Treatment

If student experiences mild symptoms:

several hives, itchy skin, itchy red watery eyes or nasal symptoms

OR if an ingestion is suspected:

Treatment:

1. Send student to health office **ACCOMPANIED.**
2. **Give _____ of _____ by mouth.**
(amount and dosage:) (antihistamine)
3. Contact the parent or emergency contact person.
4. **If exposed - Have child wash face, hands and exposed area.**
5. Stay with the student; keep student quiet, monitor symptoms, until parent arrives.
Watch student for more serious symptoms listed below.

Special Instructions:

Symptoms that progress and can cause a life threatening reaction:

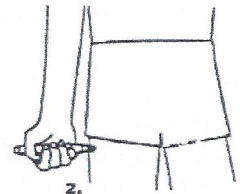
- *Hives spreading over the body.*
- *Wheezing, difficulty swallowing/ breathing, swelling (face, neck), tingling/swelling of tongue.*
- *Vomiting*
- *Signs of shock (extreme paleness/gray color, clammy skin, etc.), loss of consciousness.*

Treatment:

1. **Give:** **Epi-Pen Jr.®** OR **Epi-Pen®** immediately
(under 66lbs) (66lbs & over)

Place against upper outer thigh, through clothing if necessary.

2. **Call 911** (or local emergency response team) immediately.
3. Epi-pen® only lasts 20-30 minutes.
****Paramedics should always be called if Epi-Pen® is given****
4. Contact parents or emergency contact person. If parents unavailable, school personnel should accompany the child to the hospital.



Directions for use of Epi Pen®:

1. Pull off gray cap.
2. Place black tip against upper outer thigh.
3. Press hard into outer thigh, until it clicks.
4. Hold in place 10 seconds, and then remove.
5. Discard Epi Pen® in impermeable can and dispose per school policy, or give to emergency care responder. (Do not return to holder)

It is understood by parents and health care provider(s) that this plan may be carried out by school personnel other than the School Nurse Consultant (RN). A RN is to be responsible for delegation of this Health Care Plan to unlicensed persons.

Health Care Provider Authorization (Required): _____

Date: _____

Parent/Guardian Signature (Required): _____

Date: _____

Parent/Guardian Copy

Student Copy

School Copy

Transportation Copy

**HEALTH CARE PLAN
SEVERE ALLERGY TO: _**

Student Name: _____
Birthdate: _____

School: _____

Allergies (food, insects, medication, etc): _____ _____	Reaction: _____ _____
Diet Restrictions: For food allergies: <input type="checkbox"/> parents will monitor school lunch menus or provide food and communicate with school personnel <input type="checkbox"/> student will self monitor food choices <input type="checkbox"/> teacher will assist child unable to self select food choices <input type="checkbox"/> other	

Medications used on a daily basis (include doses): HOME: _____ SCHOOL: _____

REMINDER: School personnel must take Epi-Pen® or any other medication on all field trips. Make sure phone is close by, if needed. Keep Epi-Pen® at room temperature. DO NOT FREEZE, refrigerate or keep in extreme heat.

Pertinent Health History (as completed by School Nurse): _____

EMERGENCY INFORMATION

Parent/Guardian	Number in order of preference	Number in order of preference
Home Phone:		
Cell Phone:		
Work Phone:		
Pager Number:		
Home Address:		
Emergency Contact:	Name:	Phone:
Emergency Contact:	Name:	Phone:

Health Care Provider who should be called regarding the allergic reaction:

Name: _____
Phone: _____
Hospital Preference: _____

If _____ experiences a change in health condition (such as a change in medication or hospitalization) please contact the School Nurse (RN) so that this Health Care Plan can be revised, if needed. Parent/guardian signature indicates permission to contact the child's health care provider(s) listed above, as needed. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure this child's safety and well being while at school or during school related activities.

Parent/Guardian Signature: (Required) _____ Date _____

School Nurse (RN) Signature: (Required) _____ Date _____

Administrator Signature: (Preferred) _____ Date _____

- Parent/Guardian Copy Student Copy School Copy Transportation Copy