NORTH LAKE – ALLERGIC REACTION INDIVIDUALIZED HEALTH PLAN

(This form is to be filled out by the student's practitioner, only if student has severe allergy needing emergency medication)

Student's Name: ____ D.O.B. ___________ Ht._______ Wt._________

Teacher/Grade: ______________________ Asthmatic: Yes No * If yes, higher risk for severe reaction

ALLERGIC TO:

Number Allergan	**Allergen**	**Please circle what causes a reaction**	**Describe past reactions and medications used.**
1		Ingestion or touch or sting or airborne	
2		Ingestion or touch or sting or airborne	
3		Ingestion or touch or sting or airborne	
4		Ingestion or touch or sting or airborne	
5		Ingestion or touch or sting or airborne	
6		Ingestion or touch or sting or airborne	

Please check your child's typical allergic reaction symptoms (identify by the number of the above allergen if applicable):

_____***Lungs*** **-** difficulty breathing or wheezing _____***Heart*** **-** pale, blue, faint, dizzy _____***Mouth*** - swelling of tongue and/or lips
_____***Throat*** - tight, trouble breathing/swallowing _____***Throat*** - _____***Gut*** – nausea, vomiting, or diarrhea
change in voice quality, hoarse
_____***Skin*** - hives, widespread skin redness _____Collapse/loss of consciousness _____***Other***

STEP 1: TREATMENT

SYMPTOMS: *The severity of symptoms can quickly change. †Potentially life-threatening.* **Give Checked Medication**:
(Determined by physician authorizing treatment)

▪ If a food allergen has been ingested, but **no** symptoms . . . . □ Epinephrine □ Antihistamine ▪ Mouth Itching, tingling, or swelling of lips, tongue, mouth . . . . . . □ Epinephrine □ Antihistamine ▪ Skin Hives, itchy rash, swelling of the face or extremities . . . . . □ Epinephrine □ Antihistamine ▪ Gut Nausea, abdominal cramps, vomiting, diarrhea . . . . □ Epinephrine □ Antihistamine ▪ Throat† Tightening of throat, hoarseness, hacking cough . . . . □ Epinephrine □ Antihistamine

▪ Lung† Shortness of breath, repetitive coughing, wheezing . . . . □ Epinephrine □ Antihistamine ▪ Heart† Thready pulse, low blood pressure, fainting, pale, blueness …. □ Epinephrine □ Antihistamine ▪ Other† ____ . . . □ Epinephrine □ Antihistamine ▪ If reaction is progressing (several of the above areas affected), give . . . . . □ Epinephrine □ Antihistamine

MEDICATION ORDERS: A medication administration authorization form must accompany this form in order for medication ordered to be given.

Epinephrine: (circle one) EpiPen® EpiPen®Jr. Auvi-Q 0.3mg **Repeat dose:** (circle one) YES NO (Yellow)
(Green)
Antihistamine: ____ (medication/dose/route)
Other:____ (medication/dose/route)

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

1. Call the school nurse.
2. Administer any additional medications ordered by physician above for mild symptoms (itchy nose, itch mouth, sneezing, few hives, mild itch, or mild nausea).
3. Administer injection of epinephrine auto injector**-** ________ mg Epinephrine. Physician is to indicate change in dose below. The student, school nurse, Licensed Athletic Trainer, health room personnel, or staff trained in the administration of epinephrine auto injector will

administer the epinephrine auto-injector to the student as ordered below. No school employee, except a health care professional is required to administer any drug to a pupil by means other than ingestion.

4. If ordered administer inhaler (bronchodilator) if wheezing.
5. Transport to Emergency Room for severe allergic reaction.
   a. ______ call 911
   b. ______ call parent to transport to emergency room, call 911 if unable to reach parents
6. Administer CPR if necessary.

Parental Consent:

• I hereby give my permission for the school nurse, health room personnel, office staff or authorized school personnel to give the medication to my child according to the directions stated below.

• I give permission to the school nurse to contact the student's physician.

• **I FURTHER AGREE TO HOLD THE SWALLOW SCHOOL DISTRICT AND THE ABOVE-IDENTIFIED PERSON(S) HARMLESS IN ANY OR ALL CLAIMS ARISING FROM THE ADMINISTRATION OF THIS MEDICATION OR THE PERFORMANCE OF THIS PROCEDURE AT SCHOOL.**

• I agree to notify the health room at the termination of this request or when changes in the below orders is necessary. • If I cannot be reached by phone and my child does not respond to the medication listed below, 911 will be called to transport my child to the nearest hospital.

__________________ ______________________________________

Date Signature or Parent/Legal Guardian

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has occurred and EpiPen was administered.

2. Parent(s)________________________________ Phone Number __________________________________

____ Phone

Number____________________________________ 4. Emergency Contact: (in case parent(s) cannot be reached)

Name/Relationship _________________________ Phone Number(s) ____________________________

Parent/Guardian Signature____ Date_______________________

Doctor's Signature (required) ____ Date_______________________

Doctor's Printed Name____

Phone Number______________________ Fax Number ______________________

Epinephrine auto injector - May student self-administer and keep the epinephrine auto injector under their control in such place as their backpack, purse or pockets? _________ YES _______NO

____________________ ______________________________________

Date Physician Signature

OFFICE USE ONLY

- NOTE TIME _______AM/PM (Epinephrine given)
- NOTE TIME _______AM/PM (Antihistamine given)