SWALLOW SCHOOL – 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*** - change in voice quality, hoarse

_____***Gut*** – nausea, vomiting, or diarrhea

_____***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® (Yellow) EpiPen®Jr. (Green) Auvi-Q 0.3mg **Repeat dose:** (circle one) YES NO

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)