EMERGENCY ALLERGIC REACTION INDIVIDUALIZED HEALTH PLAN

(BEE STING, FOOD/NUT ALLERGIES)

Name_____ Date of Birth_____ Grade_____

ALLERGY TO: _____

Asthmatic: ❒ No ❒ Yes* (Higher risk for severe reaction)

Step 1: Treatment

Symptoms (★: Potentially life threatening. The severity of symptoms can quickly change.)	**Administer Checked Medication*** (To be determined by physician's order)	
If a food allergen has been ingested, but NO SYMPTOMS	❒ Epinephrine	❒Diphenhydramine
Mouth: itching, tingling, or swelling of lips tongue, mouth	❒ Epinephrine	❒Diphenhydramine
Skin: hives, itchy rash, swelling of the face or extremities	❒ Epinephrine	❒Diphenhydramine
Gut: nausea, abdominal cramps, vomiting, diarrhea	❒ Epinephrine	❒Diphenhydramine
Throat★: tightening of throat, hoarseness, hacking cough	❒ Epinephrine	❒Diphenhydramine
Lung★: shortness of breath, repetitive coughing, wheezing	❒ Epinephrine	❒Diphenhydramine
Heart★: weak or thready pulse, low blood pressure, fainting, pale, blueness	❒ Epinephrine	❒Diphenhydramine
Other★: _____	❒ Epinephrine	❒Diphenhydramine
If reaction is progressing (several of the above areas affected), give:	❒ Epinephrine	❒Diphenhydramine

Epinephrine: Inject intramuscularly **DOSAGE**:_____

❒ Student has been instructed in the proper use of his/her Epinephrine Auto-Injector and in my opinion, the student can carry and administer his/her Epinephrine.

❒ Student can carry his/her Epinephrine to and from school.

❒ Student should **NOT** carry his/her Epinephrine. ❒ Other:_____

Antihistamine: Administer: Diphenhydramine _____

Medication Amount Route

OR

Administer: _____

Medication Amount Route

Step 2: EMERGENCY CALLS

Even if the parent/guardian cannot be reached, do not hesitate to medicate.

1. CALL 911
2. DOCTOR Phone: _____
3. PARENT Phone:❒Home ❒ Cell _____ Work_____
4. Emergency contact Name_____ Relationship_____ Phone _____

Doctor's Signature: _____ Date:_____

(REQUIRED)

I hereby give permission for this Individualized Health Plan to be shared with appropriate school staff on a need to know basis. I read, understand and agree with the above plan. I will notify the school nurse in writing if there are any changes in this plan. The school nurse may communicate with the above physician via telephone and/or fax.

Parent/Legal Guardian Signature: _____ Date: _____

Non-medical trained staff trained to administer medications to student (to be filled out by school nurse)	
1.	3.
2.	4.