

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	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Diphenhydramine
Mouth★: itching, tingling, or swelling of lips tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Diphenhydramine
Skin★: hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Diphenhydramine
Gut★: nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Diphenhydramine
Throat★: tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Diphenhydramine
Lung★: shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Diphenhydramine
Heart★: weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Diphenhydramine
Other★: _____	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Diphenhydramine
If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> 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.

