ALLERGY EMERGENCY
Health Management Plan
SCHOOL YEAR: _____

STUDENT NAME:	**DOB:**
SCHOOL:	**STUDENT ID:**

MOTHER:	**FATHER:**
HOME:	**HOME:**
WORK:	**WORK:**
CELL:	**CELL:**
If parents cannot be reached call:	
Name:	**Phone:**
Physician:	**Phone:**
Hospital Preference:	

Allergic to: _____
Symptoms: _____

MILD/MINOR SYMPTOMS


Itchy, runny nose, sneezing

OR


Itchy Mouth

OR


Localized rash, a few hives

OR


Nausea, vomits 1 time

Give Antihistamine: _____Dose: _____ (by mouth)
Stay with student and observe for worsening symptoms **(if more than 1 symptom go to SEVERE)**
Notify Parent.

SEVERE SYMPTOMS


Shortness of breath, coughing, wheezing


Pale, bluish, faint, weak pulse, dizzy


Hoarseness, tight throat, difficulty swallowing


Swelling of tongue &/or lips


Several hives &/or redness all over


Vomiting more than once


Impending doom, anxiety

Give epinephrine injection Brand: _____ Dose: _____ (give in the upper, outer thigh)
CALL 911 and notify parent****
OTHER (check if applicable): ☐ Give antihistamine _____ Dose _____
☐ Give inhaler _____ Dose _____

OPTION 1 OR 2 NEEDS TO BE COMPLETED AND SIGNED BY A PHYSICIAN IF STUDENT IS TO CARRY AND/OR SELF-ADMINISTER EPINEPHRINE:

☐ **1.** I have instructed student in the proper use and dosage of his/her epinephrine auto-injector. It is my professional opinion that this student should be allowed to carry and self-administer_____(medication name and dose).

☐ **2.** This student should be allowed to carry this epinephrine auto-injector while at school and on school bus. Student is not capable of administration of this medication_____ (medication name and dose).

Physician's Signature_____ Date:_____

School Clinic: Copy of plan to be provided to Transportation Supervisor

_____ _____
PARENT SIGNATURE / DATE COUNTY SCHOOL NURSE SIGNATURE / DATE

Information about students and family is strictly confidential.

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