







ALLERGY EMERGENCY **Health Management Plan** **SCHOOL YEAR:** _____

STUDENT NAME:	DOB:
SCHOOL:	STUDENT ID:

Parent/Guardian:	Parent/Guardian:
HOME:	HOME:
WORK:	WORK:
CELL:	CELL:
If parents cannot be reached call:	
Name:	Phone:
Physician:	Phone:
Hospital Preference:	








Allergic to: _____
 Symptoms: _____

MILD/MINOR SYMPTOMS

 OR  OR  OR 
 Itchy, runny nose, sneezing Itchy Mouth Localized rash, a few hives 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: (circle) EpiPen Auvi-Q Generic Dose: _____ (inject 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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