

Durham • Freeport • Pownal

ALLERGY/ANAPHYLAXIS CARE PLAN

	Birthdate See		
School Nurse	Phone	Fax	
	Preferred Hospital		
HISTORY OF ASTHMA:	□ No □ Yes-Higher risk for severe reaction	Stude	nt Photo
ALLERGY: (check appro	opriate) To be completed by Healthcare Provider		
■ Medications (list)	:		
■ Latex: Circle: Typ	pe I (anaphylaxis) Type IV (contact dermatitis)		
■ Stinging Insects (list):		
RECOGNITION & TREAT	TMENT:		
Chart to be comp	leted by Healthcare Provider ONLY	Give CHECK	ED Medication
If food ingested	or contact w/ allergen occurs:	Epinephrine	Antihistamine
No symptoms noted	Observe for other symptoms	3	
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut +	Nausea, abdominal cramps, vomiting, diarrhea		
Throat +	Tightening of throat, hoarseness, hacking cough		
Lung +	Shortness of breath, repetitive coughing, wheezing		
Heart +	Thready pulse, low BP, fainting, pale, blueness		
Neuro +	Disorientation, dizziness, loss of consciousness		
If reaction is progress	ing (several of the above areas affected), GIVE:		
The severity of s	symptoms can quickly change. + = Potentia	lly life-threat	ening.
Antihistamine: Diphenhy This child has receivantihistamine medicine. independently as well as	outer thigh (through clothing) 0.3 mg OR 0.15 mg ydramine (Benadryl®)mg. ved instruction in the proper use of the Auto-injector: EpiPen® of the student SHOULD be allow antihistamine medicine.	ved to carry and use	e the auto-injector
☐ It is my professiona	l opinion (PCP) that this student SHOULD NOT carry his/her at	uto-injector/antihis	tamine medicine.
Healthcare Provider Sign	naturePhone:	Date	

EMERGENCY PROTOCOL:

- 1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
- 2. Call parents/guardian to notify of reaction, treatment and student's health status.
- 3. Treat for shock. Prepare to do CPR/Accompany to ER if no parent/guardians are available.



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To be completed by the Parent/ Guardian

Parent/Guardian AUTHORIZATIONS: ☐ I want this allergy plan implemented for my child and I do want my child to self carry/self administantihistamine and epinephrine. ☐ I want this plan implemented for my child and I do not want my child to self-carry/self-administer and epinephrine. Permission to Administer Medication: I request and give permission for the school nurse unlicensed trained school personnel to administer medication in this plan to my child. Information regemedication may be shared with the appropriate school personnel. NOTE: Any changes to the informati require a new Request/Permission form. Permission to Contact Prescribing Physician: I understand and agree that if the school questions regarding the physician's order, I give my permission for the school nurse to contact my child and obtain additional information about the medication, administration schedule, and the effects of the my child's learning. I consent to the physician providing that information. Medication Removal: I understand that I must pick up any medication no longer required or rene end of the school year or it will be appropriately discarded. After School Activities: I understand I am responsible for auto injectors for before and after scl. Parent Signature: Date: Student Agreement: I have been trained in the use of my auto-injector and allergy medication (antihistamine) and und signs and symptoms for which they are given; I agree to carry my auto-injector and allergy medicine with me at all time; Will notify a responsible adult Immediately when my auto-injector (epinephrine) and or allerg (antihistamine is used). I will not share my medication with other students or leave my auto-injector unattended; I will not use my allergy medications of any other use than what it is prescribed for. Student Signature: Date: Date:	Elliergency C					_	
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