Allergic Reaction Individualized Health Plan

Student Name:	**Graduation Year:**
Parent/ Guardian Name(s):	**Phone Number(s):**

Allergy Information	
Allergic to:	**_____ Peanuts** **_____ Tree Nuts** **_____ Bees, Wasps, etc.** **_____ Latex** **_____ Environmental** **_____ Other (Please list):**
Did student need epinephrine for a past reaction? _____ Yes _____ No	
Is this an allergy that requires your student to carry an epi-pen? _____ Yes _____ No	

Mild Allergic Reaction Symptoms	**SEVERE Allergic Reaction Symptoms**
_____ **Nose:** Itchy, Runny Nose, Sneezing _____ **Mouth**: Itchy _____ **Skin:** Few hives, mild rash _____ **Gut:** Mild nausea or discomfort	_____ **Lungs**: difficulty breathing, repetitive cough, or wheezing _____ **Throat**: tight, hoarse, trouble swallowing, change in voice _____ **Skin**: many hives over body, widespread skin redness _____ **Heart**: pale, blue, faint, dizzy, weak pulse _____ **Mouth**: Swelling of tongue and/or lips _____ **Gut**: severe vomiting or diarrhea _____ **Other (please list):**

Treatment / Care Plan

Treatment Care Plan:

1) Call school nurse (south x4108 or north x4208) or licensed athletic trainer.
2) Administer antihistamine (if ordered) for MILD Symptom in (1) body system (see above). Continue to monitor.
3) For **SEVERE reaction symptoms or for MILD symptoms with (2) or more body systems involved**, **administer intramuscular injection of epinephrine auto injector- adult 0.3mg IMMEDIATELY**. If dose differs, see physician order below. The student, school nurse, licensed athletic trainer, health room personnel, or staff trained in the administration of epinephrine auto injector will administer the epinephrine auto-injector as ordered below. No school employee, except a health care professional is required to administer any drug to a pupil by means other than ingestion.
4) Lay student flat, raise legs and keep warm. If breathing is difficult or student is vomiting, let them sit up or lie on their side.
5) If ordered, administer inhaler if wheezing.
6) **Transport to emergency room for SEVERE allergic reaction requiring epinephrine administration.**
   - **School will call 911.**
   - School will call parent(s) and give option for parent to transport student to emergency room. If parent is unavailable, EMS will transport student.
7) Start CPR if necessary.

Parent/ Guardian Care Plan and Medication Consent

1) I, hereby, give my permission for the school nurse, health room personnel, office staff or authorized school personnel to give the medication(s) listed below to my student according to the directions below should my student require it.
2) I, hereby, give the school nurse permission to contact the student's physician to discuss this action plan and/or medication.
3) I further agree to hold the Arrowhead School District, and the above-identified person(s) harmless in any or all claims arising from the administration of this medication.
4) I understand that this plan is valid for the student's entire duration of enrollment at AHS. I agree to provide written notification to the school nurse at the termination of this request or when any changes are made in this care plan and/or medication.
5) I understand that I must supply the emergency medication to school in the original pharmacy packaging/container. I will replace the supply if expired or it was used. I do not need to provide medication if my student will be self-carrying medication.
6) I agree to pick up the medication by the last day of school or it will be discarded. I understand that no medication will be stored over the summer.
7) I agree with the care plan listed above.

My student's epinephrine auto-injector pen will be kept in:	**_____ The front pocket of my student's backpack or purse (MD must consent.)** **_____ Health Room. I will bring injector to the Health Room prior to school starting.**
My student's antihistamine and/or inhaler (if ordered) will be kept in:	**_____ The front pocket of my student's backpack or purse (MD must consent.)** **_____ Health Room. I will bring to the Health Room prior to school starting.**

Parent/Guardian Name:	**Parent/ Guardian Signature:**	**Date:**

Physician Medication Orders

Name of Medication	Dose / Frequency	Route	When to Be Administered
May student self-administer and keep their epinephrine auto injector under their control in such place as their backpack or purse?			**_____ Yes _____ No**
If additional medications are ordered, such as antihistamine and/or inhaler, may the student self-carry, and self-administer these medications?			**_____ Yes _____ No**

Physician Name:	**Physician Signature:**	**Date:**

Health Office Personnel - Verify the Following:

1) **Physician Medication Order is properly filled out and accompanies the medication. The form must be signed by both the physician and parent and the form matches the information on the medication bottle/package.**
2) **The medication is in its original packaging with pharmacy label, and is not expired.**

FOR OFFICE USE ONLY:

DATE	AMOUNT OF MEDICATION DELIVERED/RETURNED	STAFF SIGNATURE	PARENT/GUARDIAN SIGNATURE OR SECOND VERIFIER	SKYWARD UPDATED