ONLY FOR STUDENTS CARRYING AN EPINEPHRINE AUTO-INJECTOR

ARROWHEAD HIGH SCHOOL – ALLERGIC REACTION INDIVIDUALIZED HEALTH PLAN

Student name _____ Home phone number _____

Mother's name _____ Work phone number _____

Father's name _____ Work phone number _____

Physician _____ Physicians phone _____

ALLERGIC TO:

Allergen	Please circle what causes a reaction	Describe past reactions and medications used.
	Ingestion or touch or sting	
	Ingestion or touch or sting	
	Ingestion or touch or sting	
	Ingestion or touch or sting	
	Ingestion or touch or sting	
	Ingestion or touch or sting	

Please check your child's typical allergic reaction symptoms:

____**lungs** - difficulty breathing or wheezing
____**throat** - tight, hoarse, trouble breathing/swallowing
____ **skin** - many hive over body, widespread skin redness
____ **heart** - pale, blue, faint, dizzy
____ **throat** - change in voice quality
____collapse
____ **mouth** - swelling of tongue and/or lips
____ **gut** - severe vomiting or diarrhea
____ other

Treatment Plan:

1. Call the school nurse or Licensed Athletic Trainer.
2. Administer any additional medications ordered by physician below for mild symptoms (itchy nose, itch mouth, sneezing, few hives, mild itch, mild nausea).
3. Administer injection of epinephrine auto injector-adult 0.3 mg Epinephrine. Physician is to indicate change in dose 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 to the student 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. WI ACT 334
4. If ordered administer inhaler (bronchodilator) if wheezing.
5. Transport to Emergency Room for severe allergic reaction.
   a. _____ call 911
   b. _____ call parent to transport to emergency room, call 911 if unable to reach parents
6. Administer CPR if necessary.

Parental Consent:

- I hereby give my permission for the school nurse, health room personnel, office staff or authorized school personnel to give the medication to my child according to the directions stated below.
- I give permission to the school nurse to contact the student's physician.
- 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 or the performance of this procedure at school.
- I agree to notify the health room at the termination of this request or when changes in the below orders is necessary.
- If I cannot be reached by phone and my child does not respond to the medication listed below, 911 will be called to transport my child to the nearest hospital.

_____ _____

Date Signature or Parent/Legal Guardian

TO BE COMPLETED BY A PHYSICIAN!

Physician medication orders:

Name of medication	Dosage	Time to be administered Or PRN	Duration
EPI-Pen/Auvi-Q	0.3mg/adult dose	PRN allergic reaction	Entire time at AHS

Epinephrine auto injector - May student self-administer and keep the epinephrine auto injector under their control in such place as their backpack, purse or pockets? _____ YES _____NO

_____ _____

Date Physician Signature