Health Care Plan – Allergies

This Plan expires after 6 months. In addition to the requirement to update or reauthorize the Plan at least every 6 months, the Plan must be updated whenever the child's condition, treatment plan and/or medication changes and/or whenever local licensing regulations require more frequent updates.

ALLERGY TO: ______________________________

Student's Name: ______________________ D.O.B.: __________ Teacher: ______________

Asthmatic? ☐ Yes ☐ No High Risk for Severe Reaction? ☐ Yes ☐ No Multiple Allergies? ☐ Yes ☐ No

If yes, complete Asthma Plan (180581-RSK-GEN).

List the student's symptoms: ______________________________

____

OTHER SIGNS OF AN ALLERGIC REACTION TO WATCH FOR:

SYSTEMS	SYMPTOMS
Mouth	itching and swelling of the lips, tongue, or mouth
Throat*	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
Skin	hives, itchy rash, and/or swelling about the face or extremities
Gut	nausea, abdominal cramps, vomiting, and/or diarrhea
Lung*	shortness of breath, repetitive coughing, and/or wheezing
Heart*	"thready" pulse, "passing out"

The severity of symptoms can quickly change.
****All above symptoms can potentially progress to a life-threatening situation.***

Insert or attach photo of student

ACTION FOR MINOR REACTION

If only symptom(s) are: ______________________, give ______________________
medication / dose / route

____

Then call:

Parent ______________________, Parent ______________________, or emergency contacts.

If condition does not improve within 10 minutes, follow steps below in ACTION FOR MAJOR REACTION.

ACTION FOR MAJOR REACTION

If ingestion is suspected and/or symptom(s) are: ______________________,

give ______________________ IMMEDIATELY!
medication / dose / route

Then call:

1. Emergency Medical Services (9-1-1) (ask for advanced life support)
2. Parent ______________________, Parent ______________________, or emergency contacts.

DO NOT HESITATE TO CALL EMERGENCY SERVICES!

PARENT/GUARDIAN SIGNATURE	DATE	DOCTOR SIGNATURE	DATE

 © 2001-2014 Knowledge Universe Education LLC. All rights reserved.

EMERGENCY CONTACTS

Parent: ______________________ Phone: ______________ Phone: ______________

Parent: ______________________ Phone: ______________ Phone: ______________

1. ______________________ Relation: ______________ Phone: ______________
2. ______________________ Relation: ______________ Phone: ______________
3. ______________________ Relation: ______________ Phone: ______________

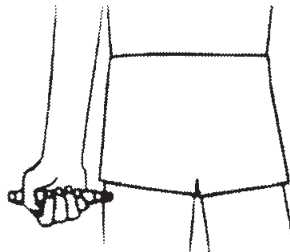
STAFF MEMBERS TRAINED ON USE OF EPIPEN®

1. ______________________________ Room: ______________
2. ______________________________ Room: ______________
3. ______________________________ Room: ______________

EPIPEN® AND EPIPEN® JR. DIRECTIONS

1. Pull off gray safety cap.

2. Place black tip on outer thigh (always apply to thigh).



3. Using a quick motion, press hard into thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and discarded. Massage the injection area for 10 seconds.

PHYSICIAN'S DIRECTIVES TO EMTs

Transportation to the hospital should be provided under the following conditions. *Staff will not prevent EMTs from transporting a child that they believe requires emergency hospital care.*

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

PHYSICIAN'S SIGNATURE	PHYSICIAN'S PHONE NUMBER	DATE SIGNED

 © 2001-2014 Knowledge Universe Education LLC. All rights reserved.