Severe Allergy Care Plan

Student Name: _____ Grade/Team_____

My child has an allergy to:

- ☐ Bee stings
- ☐ Wasp stings
- ☐ Other: _____
- ☐ Food allergy: _____

Is this a life-threatening allergy? YES NO

Allergy Management:

(Please check applicable items)

- ☐ **Administer Epi Pen intramuscularly**
- ☐ **Administer antihistamine**
  - **Medication and dose:**_____
- ☐ **Other medication:**
  - **Dosage and route:** _____
- ☐ **Call 911**
- ☐ **Call parents**

Other instructions: _____

_____

Emergency Contacts:

Name:_____ Phone # _____

Name: _____ Phone # _____

Parent Signature _____ Date _____

Nurse Signature _____ Date _____

Office Use Only

Teacher/Team Notified _____

Dietary Restriction Form _____

Medication Expiration Date _____