**SEVERE ALLERGIC REACTION (ANAPHYLAXIS) IHP**

**\*\*THIS FORM IS VALID FOR SCHOOL DAY, EXTENDED DAY, OVERNIGHT AND WEEKEND FIELD TRIPS**

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| --- | --- | --- | --- |
| Student: | | | School Year: |
| DOB: | Grade: | School: | |
| Anaphylaxis (Severe allergic reaction) is an excessive reaction by the body to combat a foreign substance that has been eaten, injected, inhaled or absorbed through the skin. It is an intense and life-threatening medical emergency. Do not hesitate to give Epi auto-injector and call 911. | | | |

**----------------------THIS SECTION TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER--------------------------**

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| --- | --- | --- | --- |
| Severe Reaction to: | | | |
| € Student has Asthma ( Increased risk for severe reaction) \*\*\*Requires additional IHP for asthma | | | |
| EpiPen (.30mg) EpiPen Jr. (0.15mg)  € Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Side Effects: Increased heart rate  Other: | |
| Antihistamine:  Dose: \_\_\_\_\_\_\_\_mg \_\_\_\_\_\_\_ml \_\_\_\_\_\_\_tabs | Side Effects: Sleepy Other: | | Only given AFTER EpiPen & IF student is able to swallow |
| Repeat dose of EpiPen: Yes No | | If YES, when: | |
| **€ Student may carry/self-administer Epi-pen/medication and has demonstrated appropriate technique.** | | | |

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| **IF YOU SEE THIS:** | **DO THIS:** | **Time/Initial** |
| Any of the Below Signs & Symptoms  Following exposure to: | Give EPI-PEN in outer thigh  Call 911  Call Parent |  |
| Breathing Stops | Begin CPR/Rescue Breathing and Elevate Legs |  |
| *\*Note time of arrival and departure of ambulance. Complete this form, initial, and send a copy of the form with the ambulance.* | | |

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| **Licensed Health Care Provider Signature:** | **Date:** | **Printed Name:** | **Phone/Fax:** |

**---------------------------------THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN------------------------------------**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Mother/Guardian: | | | Father/Guardian: | | |
| Cell: Work: Home: | | | Cell: Work: Home: | | |
| Emergency Contact: | Relationship: | | | Phone: | |
| **€ Parent agrees that student may carry and/or self-administer Epi-Pen/medication.**  \*\*\*If above checked, additional Epi-pen provided for Health Room € Yes € No | | | | | |
| **Parent/Guardian Signature:** | | **Printed Name:** | | | **Date:** |

-------------SCHOOL STAFF: See Student’s Health Plan Orders above by Licensed Health Care Provider------------

|  |  |
| --- | --- |
| SYSTEM: | SYMPTOMS: Student should NEVER BE LEFT ALONE if symptoms are present/exposure to allergen occurred |
| Mental  Mouth  Throat  Skin  Abdominal  Breathing  Heart | State feels “scared”, something bad is going to happen  Itching, tingling, or swelling of the lips, tongue or mouth  Itching and/or a sense of tightness in the throat, hoarseness, hacking cough  Hives, Itchy rash and/or swelling around face or extremities  Nausea, stomach cramps, vomiting and/or diarrhea  Shortness of breath, repetitive coughing and/or wheezing  Thready pulse, low blood pressure, fainting, pale, blueness, poor capillary refill |
| Epi auto-injector location: € Health Room € Backpack € Other: | |
| Form Received: \_\_\_\_\_\_\_\_\_ € Entered in Database € Exp. Date Checked Rvw’d by District RN: \_\_\_\_\_\_\_\_\_\_\_\_ | |