School Year_____

Health Services Department
Allergy & Anaphylaxis Medical Management & Emergency Plan

Student's Name: _____ DOB: _____ ID #: _____

Allergy: _____ Reaction: _____

Date of last known allergic episode: _____

I. At the onset of hives, itching, or swelling, take an antihistamine:

1. Hives (appearing red, itchy bumps)
2. Generalized itching especially of the palms of the hands, soles of the feet, or the groin area.
3. Swelling of face or body part.

Antihistamine _____	**Give _____mg by mouth every _____** **Side Effects:**

II. At the onset of severe rash or swelling take:

Steroid _____	**Give _____mg by mouth every _____** **Side Effects:**

III. Use injectable epinephrine (Epi-pen/Epi-pen Jr) and antihistamines if any of the following occur:

a. Light-headedness or dizziness.
b. Palpitations.
c. Shortness of breath or chest tightness.
d. Hoarseness or tightness of the throat.
e. Abdominal cramping, nausea, vomiting, or diarrhea, or difficulty swallowing, if associated with any of the above signs.

NOTE: AFTER THE USE OF AN EPI-PEN/EPI-PEN JR, CALL EMS/911 IMMEDIATELY FOR FOLLOW-UP.

Epinephrine (Check One) ☐Epi-Pen ☐Epi-pen Jr. ☐Twinject ☐ Adrenaclick ☐ AVIQ	**Dosage** ☐ 0.15mg ☐ 0.3mg	**Route:** Inject into upper outer thigh Intramuscular) **Weight:** _____lbs.

To Be Completed by Health Care Provider

I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use the medication by him/herself.

Health Care Provider's Printed Name: _____ **Date_____**

Health Care Provider's Signature: _____ **Phone: _____**

To Be Completed by Parent/Guardian:

I the parent/guardian of_____request that the above medication and procedures be administered to my child. I will notify the school nurse immediately if the health status of my child changes, I change physicians or emergency contact information, or the procedure is canceled or changes in any way. Information concerning my child's allergy and/or anaphylaxis health management may be shared with/obtained from the health care providers. *Yo, el padre/tutor de_____*
Notificaré a la enfermera de la escuela inmediatamente si el estado de salud de mi hijo cambia, cambio de médico o información de contacto de emergencia, o el procedimiento se cancela o cambia de alguna manera. La información sobre el manejo de la salud de alergia y/o anafilaxia de mi hijo se puede compartir con/obtener de los proveedores de atención médica

Parent/Guardian Signature_____ Phone (Hm) _____ Date_____

For self-carry and self-administer students only

I have been instructed on the proper use of my prescription labeled Epi-pen and fully understand how to administer this medication. I will not allow another student to use my prescription epi-pen under any circumstances. I also understand that should another student use my prescription labeled epi-pen, the privilege of carrying it with me may be revoked. I also accept the responsibility for checking in with the nurse to keep him/her informed of the use of my epi-pen in case I would self-administer.

Student's Name (print): _____ Student's Signature: _____ Date _____