Allergy/Anaphylaxis Health Care Plan

Student's Name_____ Teacher_____

Allergy to_____

Asthmatic: Yes___ No___ DOB_____ Weight_____

AN ALLERGIC REACTION MAY INCLUDE ANY OR ALL OF THESE SYMPTOMS:

Mouth- itching; swelling of lips, tongue, or mouth
Throat- itching, tightness or sense of throat closing, hoarseness, difficulty swallowing
Skin- hives, itchy rash, swelling of face or limbs, sweating
Abdomen- nausea, cramps, vomiting, diarrhea
Lung- shortness of breath, repetitive coughing, wheezing
Heart- fast, weak pulse; change in color (pallor or flushing), weakness, fainting
Other- feeling of apprehension

Action:
Provide the following medications as ordered per physician:

Benadryl: □ Yes □ No Dosage: _____

Directions for administration: _____

Epinephrine: □ Yes □ No Dosage _____
Directions for administration: _____

If epinephrine is given, emergency medical services (911) should be accessed immediately. Report that the student is having an allergic reaction and indicate that you require Advanced Life Support with additional epinephrine.

Check one of the following:

___Treatment should be initiated immediately after exposure and prior to symptoms (per healthcare provider)

___Treatment should be initiated only following the appearance of symptoms (per healthcare provider)

Healthcare provider signature_____ Date_____

Parent's Signature_____ Date_____

School Nurse's Signature_____ Date_____