







ALLERGY EMERGENCY
Health Management Plan
SCHOOL YEAR: _____

STUDENT NAME:	DOB:
SCHOOL:	STUDENT ID:

MOTHER:	FATHER:
HOME:	HOME:
WORK:	WORK:
CELL:	CELL:
If parents cannot be reached call:	
Name:	Phone:
Physician:	Phone:
Hospital Preference:	

Allergic to: _____
 Symptoms: _____








MILD/MINOR SYMPTOMS

 OR
  OR
  OR
 

Itchy, runny nose, sneezing Itchy Mouth Localized rash, a few hives Nausea, vomits 1 time

Give Antihistamine: _____ Dose: _____ (by mouth)
 Stay with student and observe for worsening symptoms **(if more than 1 symptom go to SEVERE)**
 Notify Parent.

SEVERE SYMPTOMS

Shortness of breath, coughing, wheezing Pale, bluish, faint, weak pulse, dizzy Hoarseness, tight throat, difficulty swallowing Swelling of tongue &/or lips Several hives &/or redness all over Vomiting more than once Impending doom, anxiety

Give epinephrine injection Brand: _____ Dose: _____ (give in the upper, outer thigh)
CALL 911 and notify parent****
OTHER (check if applicable): Give antihistamine _____ Dose _____
 Give inhaler _____ Dose _____

OPTION 1 OR 2 NEEDS TO BE COMPLETED AND SIGNED BY A PHYSICIAN IF STUDENT IS TO CARRY AND/OR SELF-ADMINISTER EPINEPHRINE:

1. I have instructed student in the proper use and dosage of his/her epinephrine auto-injector. It is my professional opinion that this student should be allowed to carry and self-administer _____ (medication name and dose).

2. This student should be allowed to carry this epinephrine auto-injector while at school and on school bus. Student is not capable of administration of this medication _____ (medication name and dose).

Physician's Signature _____ Date: _____

School Clinic: Copy of plan to be provided to Transportation Supervisor

 PARENT SIGNATURE / DATE COUNTY SCHOOL NURSE SIGNATURE / DATE