

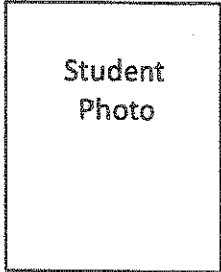
ALLERGY/ANAPHYLAXIS CARE PLAN

Name _____ Birthdate _____ Teacher _____

School Nurse _____ Phone _____ Fax _____

Healthcare Provider _____ Preferred Hospital _____

HISTORY OF ASTHMA: No Yes-Higher risk for severe reaction



ALLERGY: (check appropriate) *To be completed by Healthcare Provider*

- Foods (list):
- Medications (list):
- Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)
- Stinging Insects (list):
- Other (list):

RECOGNITION & TREATMENT:

Chart to be completed by Healthcare Provider ONLY		Give CHECKED Medication	
If food ingested or contact w/ allergen occurs:		Epinephrine	Antihistamine
No symptoms noted	<input type="checkbox"/> Observe for other symptoms		
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut+	Nausea, abdominal cramps, vomiting, diarrhea		
Throat+	Tightening of throat, hoarseness, hacking cough		
Lung+	Shortness of breath, repetitive coughing, wheezing		
Heart+	Thready pulse, low BP, fainting, pale, blueness		
Neuro+	Disorientation, dizziness, loss of consciousness		
If reaction is progressing (several of the above areas affected), GIVE:			
The severity of symptoms can quickly change. + = Potentially life-threatening.			

DOSAGE:

- ✓ Epinephrine: Inject into outer thigh (through clothing) 0.3 mg OR 0.15 mg
- ✓ Antihistamine: Liquid Diphenhydramine (Benadryl®) _____ mg. *To be given by mouth only if able to swallow.*
OR Benadryl fastmelts _____ mg. (depends on which is available) *To be given by mouth only if able to swallow*

Other: _____

This child has received instruction in the proper use of the Auto-injector: EpiPen® or Twinject® (circle one). It is my professional opinion that this student SHOULD be allowed to carry and use the auto-injector independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the auto-injector is self-administered.

It is my professional opinion (HCP) that this student **SHOULD NOT** carry an auto-injector.

This child has special needs and the following instructions apply: _____

Healthcare Provider Signature _____ Phone: _____ Date _____

EMERGENCY PROTOCOL:

Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

1. Call parents/guardian to notify of reaction, treatment and student's health status.
2. Treat for shock. Prepare to do CPR.