

PLACE
PICTURE
HERE

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

- If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
- If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.



1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: 0.1 mg IM 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

ST. LUKE'S SCHOOL ALLERGY INDIVIDUAL HEALTH CARE PLAN (IHCP)

Name: _____ DOB: _____ Allergy to: _____

Level of Allergy: (Circle) Inhalation Tactile Ingestion Unknown Age of Onset: _____

Describe symptom(s) of allergic reaction(s): _____

History of Anaphylaxis: (Circle one) Yes No Treatment: FpiPen Benadryl Other: (please specify) _____

Other health conditions/medications (e.g., Asthma): _____

Location of Epinephrine at school: Health Office (unlocked cabinet during regular school hours)

Preventive Measures

- Parent/guardian will inform bus company personnel of their child's allergy medication requirements, & emergency contact information. Parent/Guardian Initials _____
- Medications that are kept in the nurse's office are available during school hours only. For any before and after school activities (*Including C.A.M.P.*), it is the parent/guardian responsibility to inform activity coordinator of their child's allergy, treatments & provide emergency medications.
Parent/Guardian Initials _____
- School personnel who may be involved in the care of a student who has been diagnosed with an allergy, will be informed of the EHCP and IHCP.
- The student will be accompanied to the health office in the event of an allergic reaction.
- Trained school personnel will carry the prescribed emergency medication(s), and a copy of the EHCP on the field trip and accompany student at all times if the parent is not present. NOTE: Student may self-carry with doctor orders.
- Other Provisions required:

EMERGENCY CONTACTS (please print) Treat student before calling Emergency Contacts. - CALL 911

Parent/Guardian: _____ Phone: (____) ____ - ____

Parent/Guardian: _____ Phone: (____) ____ - ____

Other: Name/Relationship: _____ Phone: (____) ____ - ____

Parent/Guardian Authorization Signature Date

Certified School Nurse Teacher Authorization Signature Date