Holly Area Schools

Severe Allergy Medical Care Plan

Student's Name: _____ School Year :_____

Date of Birth: _____ School/Program: _____

Age: _____ Grade: _____ Teacher: _____

ALLERGY: (Check appropriate box and list specific allergen)

☐ Foods: If nuts, please specify by circling one or both: Peanut Tree Nut

_____

_____

☐ Latex

☐ Stinging Insects: _____

☐ Other: _____

_____

History of Asthma: ☐ Yes ☐ No

If your child needs medication at school for asthma, please complete a separate Asthma Care Plan.

Contact Information

First Contact	**Second Contact**
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone (1): _____	Phone (1): _____
Phone (2): _____	Phone (2): _____

Third Contact (If a parent/guardian cannot be reached)

Name: _____ Relationship: _____

Address: _____ Phone: _____

☐ YES ☐ NO I would like to talk with the school nurse regarding my child's allergies.
☐ YES ☐ NO If my child is to self-carry epinephrine, I will still supply the school with a back up auto-injector.
☐ YES ☐ NO I have read the attached information regarding section 504 eligibility.
☐ YES ☐ NO I wish to be contacted regarding a 504 evaluation.

Page one of this care plan is to be completed, signed and dated by a parent/guardian.
Page two of this care plan is to be completed, signed and dated by the treating physician or licensed prescriber.
Without signatures this care plan is not valid. The parent/guardian is responsible for supplying all medication.

I agree to have the information in this two page plan shared with staff as needed. I understand that my child's name may appear on a list with other students having severe allergies to better identify needs. I give permission for Holly Area Schools (HAS) staff to give the medication(s) as ordered on page two of this care plan for allergic reactions and to contact the physician/licensed prescriber for clarification of orders, if needed. I will not hold the HAS Board of Education or its personnel responsible for complications related to the medication.

_____ _____

Parent Signature **Date**

Holly Area Schools do not have medical personnel present to administer medication / treatment. If appropriate, please order medication / treatment to be administered at home.

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☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

Mild Symptoms → **Monitoring**

- Give Antihistamine
- Stay with student. Call parent/guardian
- If Symptoms progress: **USE EPINEPHRINE** (see below)
- Begin monitoring

Stay with Student

Any SEVERE SYMPTOMS after suspected or known ingestion: → **Inject Epinephrine Immediately**

One or more of the following:
Lung: Short of breath, wheeze, repetitive cough
Heart: Pale, blue faint, weak pulse, dizzy, confused
Throat: Tight, hoarse, trouble breathing/swallowing
Mouth: Obstructive swelling (tongue and/or lips)
Skin: Many hives over body

Or **combination** of symptoms for different body areas:
Skin: Hives, itchy rashes, swelling (ie: eyes, lips)
Gut: Vomiting, cramp type pain

Call 911 and parent/guardian
Give additional medication* (if ordered)
Antihistamine
Inhaler
Tell rescue staff that epinephrine was given and the time of administration. For severe reaction, consider keeping student lying on on back with legs raised. Keep head to side if vomiting. Treat student even if parents cannot be reached.

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan

Epinephrine dose: ☐ .15 (junior) ☐ .3 (adult)

Note: *If a student is to self-carry their epinephrine, help may still be needed to give the medication.*

Antihistamine name: _____ Dosage (please do not give a range): _____
(Note: Liquid is faster acting than a pill form)

Other Medication: _____ Dosage: _____ Time: _____

Other instructions or orders: _____

_____

Physician/Licensed Prescriber Name (Print): _____

Phone Number: _____ **Fax Number:** _____

Signature: _____ **Date:** _____

Fax this form to (248) 328 - _____