

SEVERE ALLERGY CAREPLAN 2014-2015

Student Name _____

D.O.B. _____ Grade _____

Allergy _____

PLACE A PICTURE
OF YOUR CHILD
HERE.

Type of reaction: Ingestion Contact Inhalation Is your child asthmatic? yes no

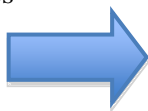
Date of Diagnosis _____ Date of last reaction _____

Has your child ever had a serious reaction? Date: _____

If so, please describe what happened and treatment required: _____

SYMPTOMS OF A SEVERE ALLERGIC REACTION:

- MOUTH** itching, swelling of lips, tongue, or mouth
- THROAT*** itching, tightness/closure, hoarseness
- SKIN** itching, hives, redness, swelling
- GUT** nausea, vomiting, cramps, diarrhea
- LUNG*** shortness of breath, coughing, wheezing
- HEART*** pale, weak pulse, confused, dizzy, passing out



If you suspect a severe allergic reaction:

- 1. INJECT EPIPEN or AUVI-Q IMMEDIATELY!** (if trained, if not, call for trained staff person to administer)
- 2. Call 911**
(State Epinephrine has been given and time given)
3. Notify School Nurse
4. Initiate Medical Emergency Response Protocol
5. Stay with student; have him/her lie down and remain lying down
6. Monitor for further signs of allergic reaction

The severity of symptoms can quickly change. *All above symptoms can progress to a life-threatening situation!

Medications/Doses

Epinephrine Brand: Epi-pen Auvi-Q Other _____

Epinephrine Dosage: 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

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

STUDENTS ARE EXPECTED TO CARRY THEIR OWN EPI-PEN AT ALL TIMES, and it is recommended that a spare Epi-pen be kept in the nurse's office.

All medication supplied to health office must come in the original container. The container must specify the student's name, name of prescriber, name of medication, dose, effective date and directions for administration.

I understand that the medication maintained in the Health Office may not be readily available after school hours, and that I need to provide additional rescue medications for my child when involved in before/after school activities.

Yes No

I give my permission for the use of my child's photograph for this purpose and to share medical information with appropriate school related personnel Yes No

I give permission for the school nurse or his/her delegated personnel to administer the medications at school or on school related events. Yes No

This student has permission to self-administer the medications at school or on school related events, if the school nurse deems it is appropriate. Yes No

My child will carry his/her own EpiPen/Auvi-Q: for any before/after school activities, on field trips, on bus.

EMERGENCY CONTACTS:

Name: _____ Relation: _____ Phone(s) _____

Name: _____ Relation _____ Phone(s) _____

Parent's Signature _____ **date** _____

Doctor's Signature _____ **date** _____

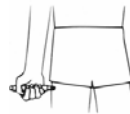
School Nurse Signature _____ **date** _____

EpiPen® Directions:

Pull off blue activation cap.



- **Hold tip near outer thigh (may be given through clothing).**
- **Press hard into thigh until it clicks.**
- **Hold in place and count to 10.**
- **Remove the EpiPen®; massage the injection area for 10 seconds.**



Auvi-Q Directions:

Remove device from case to activate and then pull off red safety valve

- **Please black end against outer thigh.**
- **Press firmly and hold for 5 seconds.**
- **A red light will flash when injection is complete.**