LOGAN COUNTY SCHOOLS
SEVERE ALLERGY AND HEALTH CARE & EMERGENCY RESPONSE PLAN

STUDENT: _____ D.O.B.: _____ Plan Date: _____ _____

SEVERELY ALLERGIC TO: ❑ Peanuts/Peanut Butter ❑ Eggs ❑ Milk ❑ Nuts (Specify _____) ❑ Seafood (Specify _____)

❑ Latex ❑ Insect Bites (Specify _____) ❑ Other _____

Parent/Guardian & Phone: _____

Parent/Guardian & Phone: _____

Alternate Emergency Contacts:

1. _____ Phone: _____
2. _____ Phone: _____

Medical Provider: _____ Office: __ Fax: _____

ACTION TO TAKE IF THE STUDENT IS KNOWN OR SUSPECTED TO HAVE EATEN ALLERGY CAUSING FOOD

If allergen exposure is known, but no symptoms: ❑ Observation ❑ Antihistamine ❑ EpiPen®

Antihistamine: Dose & Route _____

Notify Parent: When student has known or suspected exposure to allergen

Call 911 if: Epinephrine is administered; OR student exhibits a symptom of severe respiratory distress; OR student exhibits symptoms and epinephrine is not available

The severity of symptoms can quickly change:

Symptoms:	*Action To Take:* (To be determined by physician authorizing treatment)
Mouth: Itching, tingling or swelling of lips, tongue, mouth	Antihistamine dose/route: _____ EpiPen®
Skin: Hives, itchy rash, swelling of the face or extremities	Antihistamine dose/route: _____ EpiPen®
Gut: Nausea, abdominal cramps, vomiting, diarrhea	Antihistamine dose/route: _____ EpiPen®
Throat: Tightening of throat, hoarseness, hacking cough	Antihistamine dose/route: _____ EpiPen®
Lungs: Shortness of breath, repetitive coughing, wheezing	Antihistamine dose/route: _____ EpiPen®
Heart: Thready pulse, low blood pressure, fainting, pale, blueness	Antihistamine dose/route: _____ EpiPen®
Other: _____	Antihistamine dose/route: _____ EpiPen®

EVEN IF A PARENT/GUARDIAN CAN NOT BE REACHED

DO NOT HESITATE TO GIVE MEDICATION AS AUTHORIZED, CALL 911 & ALLOW TRANSPORTATION TO THE HOSPITAL

Administer the student's epinephrine as directed:

- ❑ Staff must administer epinephrine for the student if it is needed.
- ❑ The student can self administer epinephrine. If the student isn't able to, staff must administer it if it is needed.

Medications Authorized For Use During An Allergic Reaction

Medications	*Strength*	*Dose*	*Time*	*Route*	*Possible Side Effects*	*Home*	*School*

This Health Care Plan will be shared confidentially on a need to know basis with school staff.

It reflects the patent/guardian's best understanding of their child's health condition.

This Allergy Health Plan will be reviewed each school year.

Parent/Guardian Signature_____ Date_____

Physician Authorization

I authorize the above plan to be followed in the school.

_____ _____ _____

Physician's Signature Printed Name of Physician Date