



Individual Health Plan Severe Allergic Reaction

Student Photo

Name:	Birth Date:
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Specify Anaphylactic Allergen (*Indicate if contact allergy and/or ingestion only allergy*):

- Insect stings, Specify: _____
- Nuts, Specify: _____ Contact allergy__ Ingestion only allergy__
- Other, Specify: _____ Contact allergy__ Ingestion only allergy__

Symptoms: *Can change quickly and rapidly progress to a life-threatening situation!*

- **Mental:** Feels “scared”; something bad is going to happen
- **Respiratory:** Itching or swelling of lips, tongue, mouth, throat, hoarseness, coughing, difficulty breathing
- **Skin:** Hives, itching, swelling, red/blotchy skin
- **Gut:** Nausea, vomiting cramps diarrhea
- **Heart:** Irregular pulse rapid pulse fainting

Health Care Provider to Complete

- No**, this condition is not life threatening. No intervention is needed at this time.
- No**, this condition is not life threatening. Accommodations needed (see below).
- Yes**, this is a life threatening condition. A medication order and action plan is needed (see below for plan and complete attached medication form).

Action Plan: If sending student anywhere, send with an escort

Call 911 if:	Then do:
<ul style="list-style-type: none"> • Epi pen is used • Student is unable to breathe • Student is bright red all over • Student becomes unconscious 	<ul style="list-style-type: none"> • Stay with student • Begin CPR if the need arises • Have another school employee contact parents and school nurse if not in building
<p>Further instructions from HCP: (<i>classroom, school bus, field trips, disaster etc.</i>)</p>	

Health Care Provider Signature:	Date:
Parent Signature:	Date:
School Nurse Signature:	Date:

Date Reviewed with Parent

Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature