HEALTH CARE PLAN
SEVERE ALLERGY TO: ______________________________

Student/Child Name___________________ Birth Date ___________ School/Center:________________

Emergency Treatment

FOR MILD SYMPTOMS

If student experiences mild symptoms of:

- Swelling at site of an insect sting,
- Several hives
- Itchy skin

OR if an ingestion (or sting) is suspected:

Treatment:

1. Send student to health office **ACCOMPANIED.**
2. **Give __________ of __________ by mouth.**
   Dose medication
3. **Contact** the parent or emergency contact person.
4. **Stay** with the student, keep student quiet, monitor symptoms, until parent arrives.
5. **Watch** student for more serious symptoms listed below.

Special Instructions (for health care provider to complete):

Severe Symptoms can cause a LIFE THREATENING REACTION:

- Wheezing, difficulty swallowing/breathing
- Swelling (face, neck), tingling/swelling of tongue
- Vomiting
- Signs of shock (extreme paleness/gray color, clammy skin, etc.)
- Loss of consciousness

Treatment:

1. **Give ☐Epi-PenJr.0.15 mg® (<66lbs.) OR ☐Epi-Pen0.3 mg® (>66lbs.) immediately,** place against upper outer thigh, through clothing if necessary.
2. **Call 911** (or local emergency response team) immediately. Epi-pen® only lasts 20-30 minutes. ***911 (emergency response team) should always be called if Epi-Pen® is given***
3. Contact parents or emergency contact person. If parents unavailable, school personnel should accompany the child to the hospital.

Directions for use of Epi Pen®:

1. Pull off gray safety cap.
2. Place black tip against upper outer thigh.
3. Press hard into outer thigh, until it clicks.
4. Hold in place 10 seconds, then remove.
5. Discard Epi Pen® in impermeable can and dispose per school policy, or give to emergency care responder (Do not return to holder)

It is understood by the parent/guardian(s) that this plan may be carried out by school personnel other than the school nurse. A registered nurse is to be responsible for delegation of this health care plan to an unlicensed person.

Health Care Provider"s Signature ________________________________Date ________________________________

Parent/Guardian Signature ____________________________________Date ________________________________

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Approved by The Children's Hospital, Kaiser Permanente, and Denver Health and Hospitals Authority in collaboration with the Colorado Department of Education Nurse Consultant and Colorado School Nurse Committee (2004).

HEALTH CARE PLAN

SEVERE ALLERGY TO: ___________________________

Student/Child Name__________________ **Birth Date** __________ **School/Center:**________________

Allergies (food, insects, medication, etc):

____
____
____

Reaction: (include date of last reaction)

____
____
____

Diet Restrictions:
For food allergies: ☐ parents will monitor school lunch menus or provide food, ☐ student will self monitor food choices ☐ teacher will assist child unable to self select food choices
☐ other

Medications used on a daily basis (include doses):

____
____

<u>REMINDER</u>: School personnel must take Epi-Pen® or any other medication on <u>all</u> field trips.
Make sure phone is close by, if needed. Keep Epi-Pen® at room temperature.
DO NOT FREEZE, refrigerate or keep in extreme heat.

Pertinent Health History (as completed by School Nurse):

EMERGENCY INFORMATION

	Parent/Guardian Name Number in order of preference		Parent/Guardian Name Number in order of preference	
Home Phone:				
Cell Phone:				
Work Phone:				
Pager Number:				
Home Address:				
Emergency Contact:	**Name:**	**Phone:**		
Emergency Contact:	**Name:**	**Phone:**		

Health Care Provider who should be called regarding the allergic reaction:

Name: ____
Phone: ____
Hospital Preference:

If _____________ experiences a change in health condition (such as a change in medication or hospitalization) please contact the School Nurse (RN) so that this Health Care Plan can be revised, if needed. Parent/guardian signature indicates permission to contact the child's health care provider(s) listed above, as needed. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure this child's safety and well being while at school or during school related activities.

Parent/Guardian Signature: (Required)______________________________________ Date _______________

School Nurse (RN) Signature: (Required)____________________________________ Date _______________

Administrator Signature: (Preferred)_______________________________________ Date _______________

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HEALTH CARE PLAN

SEVERE ALLERGY TO: ______________________________

***This Health Care Plan and any nurse delegation related to this plan are for use during regular school hours (8:10 a.m. – 3:20 p.m.). Medication questions outside of regular school hours need to be referred to the child's parents, Poison Control or 911. If a parent can attend a before/after school activity, they can assume responsibility for the medication.**

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