ALLERGY INDIVIDUAL HEALTH PLAN

(Parent/guardian to complete this form)

STUDENT NAME _____ DOB _____ SCHOOL _____

GRADE _____ TEACHER _____ SCHOOL YEAR _____

PARENT/GUARDIAN _____ BEST CONTACT/PHONE NUMBER _____

PHYSICIAN _____ PHONE _____

ALLERGY SPECIALIST _____ PHONE _____

What is your child allergic to (type of food, specific medications, type of insect, etc.)?

Please describe what happens with your child during an allergic reaction (symptoms, etc.):

Does your child have a doctor's order for Benadryl or Zyrtec (generic: Cetirizine) to be given at school and is this medication at school? ☐ Yes ☐ No

Does your child have a doctor's order for an injectable Epinephrine (example: Epi-pen, Epi-pen Jr., Auvi-Q, or generic Epi-pen) to be given at school, and is this medication at school? ☐ Yes ☐ No

Has your child been to an emergency room due to an allergic reaction in the past year? ☐ Yes ☐ No If yes, please describe:

Has your child had a severe allergic reaction that required injectable epinephrine, such as an Epi-pen, be given in the past? ☐ Yes ☐ No If yes, when?

In the event that you cannot be reached, please list the name(s) and phone number(s) of persons who are familiar with your child's allergy and have knowledge of how to manage an allergic reaction. *Please also add this person(s) to your child's pick-up list in case they may need to pick your child up from school due to their allergy.*

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Is there anything else you would like school staff to know about your child's allergy/allergies?

PLEASE NOTE: We recommend an Emergency Action Plan, completed by a doctor, for all children with a severe allergy. Please review the back of this form for steps school staff may take in the event of a medical emergency. These will be followed if your child does not have an Emergency Action Plan at school for this condition.

☐ I give permission for my child, _____, to receive care for the medical condition listed above by designated school staff.

☐ School nurse may share information regarding this condition with my child's doctor.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

SCHOOL NURSE SIGNATURE _____ DATE _____

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Emergency: Anaphylaxis (Severe Allergic Reaction)

STUDENT NAME _____

ALLERGIC TO _____

Note: If student also has an Emergency Action Plan (EAP) for this condition, please refer to the EAP for actions school staff should take instead. Otherwise, follow the steps below.

This student has an EAP: ☐ Yes ☐ No **Symptoms:**

- ☐ Tightness, itching, or swelling of the throat
- ☐ Hoarseness
- ☐ Coughing, wheezing, chest pain, chest tightness, or difficulty breathing
- ☐ Swelling or itching of the lips or tongue
- ☐ Uneasy sensation or agitation
- ☐ Generalized hives
- ☐ Severe itching, redness, or swelling of the skin
- ☐ Nausea and vomiting, diarrhea, or abdominal cramps
- ☐ Stomach pain
- ☐ Heart failure
- ☐ Irregular heartbeats, or a weak pulse
- ☐ Stuffy or runny nose and/or sneezing
- ☐ Dizziness or confusion
- ☐ Fainting or shock

Interventions:

1. Stay with student; student should not leave location or be left alone.

2. Call 911. Notify front office to direct EMS to student's location.

3. Call or radio for help. Designated first responder school staff should respond to the student's location, and bring any needed emergency equipment including injectable epinephrine (Epi-pen).

4. Notify parents/guardians, or designate another staff member to notify:

   Parent/guardian name: _____ Phone number: _____

   Emergency contact name: _____ Phone number: _____

5. Notify school nurse, if in building. If school nurse is not present, notify upon return or via other communication.

Additional information:

_____

_____

_____

_____

Reference: https://www.chop.edu/conditions-diseases/anaphylaxis Revised 4/2020 ALB