

PROVIDENCE CHRISTIAN ACADEMY
2023-2024
ALLERGY MEDICAL MANAGEMENT PLAN
(To be completed by Physician/ Healthcare Provider)

Name: _____ D.O.B: _____ School Yr. _____

Parent _____ Primary Phone # _____

Physician _____ Phone _____

_____ **Please check here if your child has no allergies requiring treatment during school.**

SEVERE ALLERGY TO: Peanuts Milk Fish Soy Sesame Seed/ Sesame Oil
 Eggs Shellfish Tree Nuts (pecans, walnuts, etc.) Wheat Chocolate Bees Ants
 Latex Other _____ Asthma Yes No (Higher risk for severe reaction if asthmatic)

Location(s) where EpiPen®/ Rescue Medicine is/are stored:

School health room with school nurse Backpack On person Waist pack Other _____

TREATMENT

Symptoms/Presenting complaint:

- If a **food allergen** has been ingested, but **no symptoms**
- **MOUTH-** Itching, tingling, or swelling of lips, tongue, mouth
- **SKIN-** Hives, itchy rash, swelling of the face or extremities
- **GUT-** Nausea, abdominal cramps, vomiting, diarrhea
- **THROAT-** Tightening of throat, hoarseness, hacking cough
- **LUNG**-** Shortness of breath, repetitive coughing, wheezing
- **HEART**-** Thready pulse, low blood pressure, fainting, pale, blueness
- **OTHER**** _____
- If reaction is progressing (several of the above areas affected), give

Give Checked Medication:

(To be determined by physician authorizing treatment)

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
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| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

**Potentially life-threatening. The severity of symptoms can quickly change.

MEDICATIONS

Epinephrine: inject intramuscularly EpiPen® 0.3 mg EpiPen® Jr. 0.15 mg Twinject™ 0.3 mg Twinject™ 0.15 mg

Repeat dose of epinephrine: Yes No If **yes**, when _____

Child may self administer epinephrine: Yes No

Antihistamine: give _____

Medication/ dose/ route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

EMERGENCY CALLS

Call 911 immediately. 911 must be called WHENEVER EpiPen® has been administered.

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Authorization for Health Care Provider and School Nurse to Share Information:

I authorize my child's school nurse to assess my child in regards to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

(Required)

Notes _____

Signature below indicates that the plan is reviewed and appropriate documentation is complete.

School Admin Signature _____ Date _____