PROVIDENCE CHRISTIAN ACADEMY

ALLERGY MEDICAL MANAGEMENT PLAN

(To be completed by Physician/ Healthcare Provider)

It is not necessary to complete this form if your child has no major allergies requiring treatment during school.

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

Parent _____ Primary Phone _____

Physician _____ Phone _____

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 PLAN

Symptoms/Presenting complaint:

Give Checked Medication:

(To be determined by physician authorizing treatment)

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

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

MEDICATIONS

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

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

911 must be called WHENEVER EpiPen® has been administered. EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY! Initial _____

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 _____