PROVIDENCE CHRISTIAN ACADEMY

Allergy Medical Management Plan

Name: _____

D.O.B.: _____

School Year: _____

Parent: _____ Primary Phone: _____

Physician: _____ Phone Number: _____

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: _____

Situation	Give Checked Medication (To be determined by physician)
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!

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

I authorize my child's school nurse to assess my child regarding 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:
_____
_____