

Clarksville-Montgomery County School System
HEALTH SERVICES
SEVERE ALLERGY INDIVIDUAL HEALTH CARE PLAN
School Year 20__ - 20__

*****Parent/guardian completes page one*** PLEASE PRINT*** Physician completes page two*****

Name: _____ Age: _____

Teacher: _____ Grade: _____

Parent(s)/Guardian(s): _____

Contact information - phone or pager numbers at home/work for parent(s)/guardian(s)

Other contacts (please list two); in event that parent/guardian cannot be reached:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Health Care Provider Information

Physician: _____ Phone Number: _____

Hospital (In event that your child needs hospital care): _____

Allergies

_____ honeybee _____ wasp _____ hornet _____ yellow jacket
_____ food(s) _____

_____ other _____

Symptoms of student's allergic response

_____ local swelling	_____ weakness	_____ headache	_____ shortness of breath
_____ flushed face	_____ wheezing	_____ cramping	_____ feeling of apprehension
_____ chest tightness	_____ vomiting	_____ hives	_____ excessive perspiration
_____ diarrhea	_____ choking	_____ tingling mouth	
_____ dizziness	_____ fainting	_____ feeling of body warmth	
_____ rash/itchy rash	_____ coughing		
_____ itchy, watery eyes	_____ itching or swelling of tongue or throat		
_____ other			

Emergency medication(s)

Name	Dose/Route	When to use
_____	_____	_____
_____	_____	_____

Child's Limitations or Special Considerations: _____

I understand that it is my responsibility to keep this information current.
Parent/guardian will be notified in event of a SEVERE ALLERGIC EPISODE!

Parent's Signature: _____ Date: _____

STEPS FOR A SEVERE ALLERGIC EPISODE

Student Name: _____ DOB: _____

Action Plan for Severe Allergic Episode

- _____ Student should carry an emergency kit (Ana Kit, EpiPen, etc) on their person at all times.
- _____ Student is able to self-administer emergency kit.
- _____ Student is aware of allergic reaction symptoms, and indications for administration of emergency kit.
- _____ Student is unable to self-administer emergency kit.

ACTION FOR MINOR REACTION

If **symptom(s)** are: _____

Medication(s)	Dose	Route	When to use	Can medication be repeated?	How soon?
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Other instructions/comments: _____

- _____ NOTIFY PARENT
- _____ IF CONDITION DOES NOT IMPROVE WITHIN _____ MINUTES
- _____ FOLLOW INSTRUCTIONS FOR MAJOR REACTION
- _____ CALL 911 FOR EMERGENCY CARE

ACTION FOR MAJOR REACTION

If **symptom(s)** are: _____

Medication(s)	Dose	Route	When to use	Can medication be repeated?	How soon?
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Other instructions/comments: _____

- _____ NOTIFY PARENT
- _____ CALL 911 FOR EMERGENCY CARE

NOTE: IF AN EPIPEN OR ANA KIT IS ADMINISTERED, EMS (911) IS CALLED!

Physician's Name: _____ Date: _____

Physician's Signature: _____