Allergy Health Care Plan

Student's Name:____ Birthdate: ___/___/___ Bus Y__ N___

School:____ Teacher:____________________________ Grade______

Parent/Guardian: ____ Phone:_______________________________

____ Phone: _______________________________

Emergency Contact: 1) ___________________________________ Phone: ________________________________

2) ___________________________________ Phone: ________________________________

Physician: ____ Phone/Fax: _____________________________

Allergist: ____ Phone/Fax: _____________________________

ALLERGIC TO: ____

History of Asthma: * Y____ N____ History of Anaphylaxis * Y___ N___ (* Higher risk for severe reaction)

Describe History:____

If Student Has These Symptoms: **Potentially life threatening. The severity of the symptoms can change quickly**
Mouth: itching, tingling, or swelling of lips tongue ,mouth
Skin: Hives, itchy rash, swelling of the face or extremities
GI: Nausea, abdominal cramps, vomiting, diarrhea
Throat:* tightening of throat, hoarseness, hacking cough
Lung:* Shortness of breath, repetitive cough, wheezing
Heart:* Weak, thready, pulse, low blood pressure, fainting, pale, blueness
Other:*

EPINEPHRINE TYPE and DOSE:

- EpiPen Jr. (0.15 mg)
- EpiPen (0.3mg)
- AuviQ (0.15MG)
- AuviQ (0.3 MG)

May carry and self-administer medication Y____ N_____

ANTIHISTAMINE TYPE and DOSE:

- Benadryl (also known as Diphenhydramine)
- 12.5mg (2 teaspoon or 1 chewable)
- 25 mg (2 teaspoon or 2 chewable or 1 tab)
- 50mg (4 teaspoon or 4 chewable or 2 tab)
- Other Antihistamine _________________________

Parent/Guardian Signature:_____________________________________ Date_____________________

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