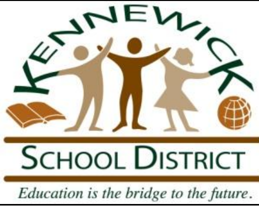

Individual Health Plan
Severe Allergic Reaction

Student Photo

Name:	Birth Date:

Specify Anaphylactic Allergen ***(Indicate if contact allergy and/or ingestion only allergy*)**:

☐ Insect stings, Specify: ______________________
☐ Nuts, Specify: ____________________________ Contact allergy__ Ingestion only allergy___
☐ Other, Specify: ____________________________ Contact allergy__ Ingestion only allergy___

Symptoms: *Can change quickly and rapidly progress to a life-threatening situation!*

- **Mental:** Feels “scared”; something bad is going to happen
- **Respiratory:** Itching or swelling of lips, tongue, mouth, throat, hoarseness, coughing, difficulty breathing
- **Skin:** Hives, itching, swelling, red/blotchy skin
- **Gut:** Nausea, vomiting, cramps, diarrhea
- **Heart:** Irregular pulse, rapid pulse, fainting

Health Care Provider to Complete

☐ **No**, this condition is not life threatening. No intervention is needed at this time.
☐ **No,** this condition is not life threatening. Accommodations needed (see below).
☐ **Yes**, this is a life threatening condition. A medication order and action plan is needed (see below for plan and complete attached medication form).

Action Plan

**Never send student alone; call office for help or to notify coming with escort

Do: : If having symptoms of allergic reaction or known exposure	**Then do:**
• **Give Epi-Pen** • **Call 911**	• Stay with student • Begin CPR if the need arises • Have another school employee contact parents and school nurse if not in building
Further instructions from HCP: ***(classroom, school bus, field trips, disaster etc.)***	

Health Care Provider Signature:	Date:
Parent Signature:	Date:
School Nurse Signature:	Date:

Date Reviewed with Parent

Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature