MD COMPLETION FOR ALL STUDENTS
INDIVIDUALIZED **HEALTH PLAN**
FOR ANAPHYLAXIS/SEVERE ALLERGIES

STUDENT:_____DATE OF BIRTH:_____GRADE:_____
ALLERGY TO:_____CELL PHONE:_____
PARENT/GUARDIAN:_____HOME PHONE:_____
MD:_____MD PHONE:_____HOSPITAL CHOICE:_____
This student has an allergy to Food or Bee Stings, an emergency may occur:

1. Administration of auto-injector of Epi-Pen as per MD instructions by nurse or staff delegate.
2. Notify Principal immediately
3. **Call 911: State who you are, where you are and the problem. Stay on phone until told to hang up.**
4. Stay with student or designate another adult to do so, continue to check pulse and respiration, prepare for CPR
5. Student MUST go to the Hospital for medical evaluation after Epinepherine Injection.
6. ***If emergency occurs on school trip; pull off road call 911***

INDIVIDUALIZED HEALTH PLAN

For completion by MD

If you see these symptoms: Do this:

_____

_____

_____

Mouth: itching & swelling of lips, tongue or mouth
Abdomen: nausea, cramps, vomiting or diarrhea
Heart; threaded pulse, passing out, unconsciousness
Throat: itching and or a sense of tightness in throat
Skin: hives, itchy rash, swelling of face or extremities
Lung: shortness or breath, repetitive coughing/wheezing

PHYSICIAN SIGNATURE:_____**DATE:**_____

Delegates to Administer an EpiPen for this student: no oral meds.

1. Delegate Name:_____Signature:_____Date:_____
2. Delegate Name:_____Signature:_____Date:_____

Parent/Guardian Signature:_____Date:_____
School Nurse Signature:_____Date:_____
Principal Signature:_____Date:_____

6/07