Western School Corporation
PLAN OF CARE- SEVERE ALLERGY
(Must be completed by Physician)

Name: ____ Grade________Age_____
Last name First MI

School Building: ______________________________________

Parent /Guardian Name: ______________________________ Phone (H)_____________

Address: ____Phone (W)____________

Emergency Phone Contact #1: ____
Name Relationship Phone

Emergency Phone Contact #2 ____
Name Relationship Phone

Physician Student Sees for Allergy: ______________________________________
Phone

Other Physician: ____
Phone

ALLERGIES: (Please list your child's allergies and symptoms)
____
____
____

Has your child had a reaction before? ____________ Please list the date, symptoms, and treatment of episode:
____
____

♦ Step 1: TREATMENT ♦

Symptoms:		**Give Checked Medications:** (To be determined by physician authorizing treatment)	
• 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*	Weak or 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.

DOSAGE

Epinephrine:
Inject intramuscularly (circle one) EpiPen® EpiPen®Jr. Twinject® 0.3 mg Twinject® 0.15 mg
(see reverse side for directions)

Antihistamine: give ____
Medication/Dose/Route

Other: give ____
Medication/Dose/Route

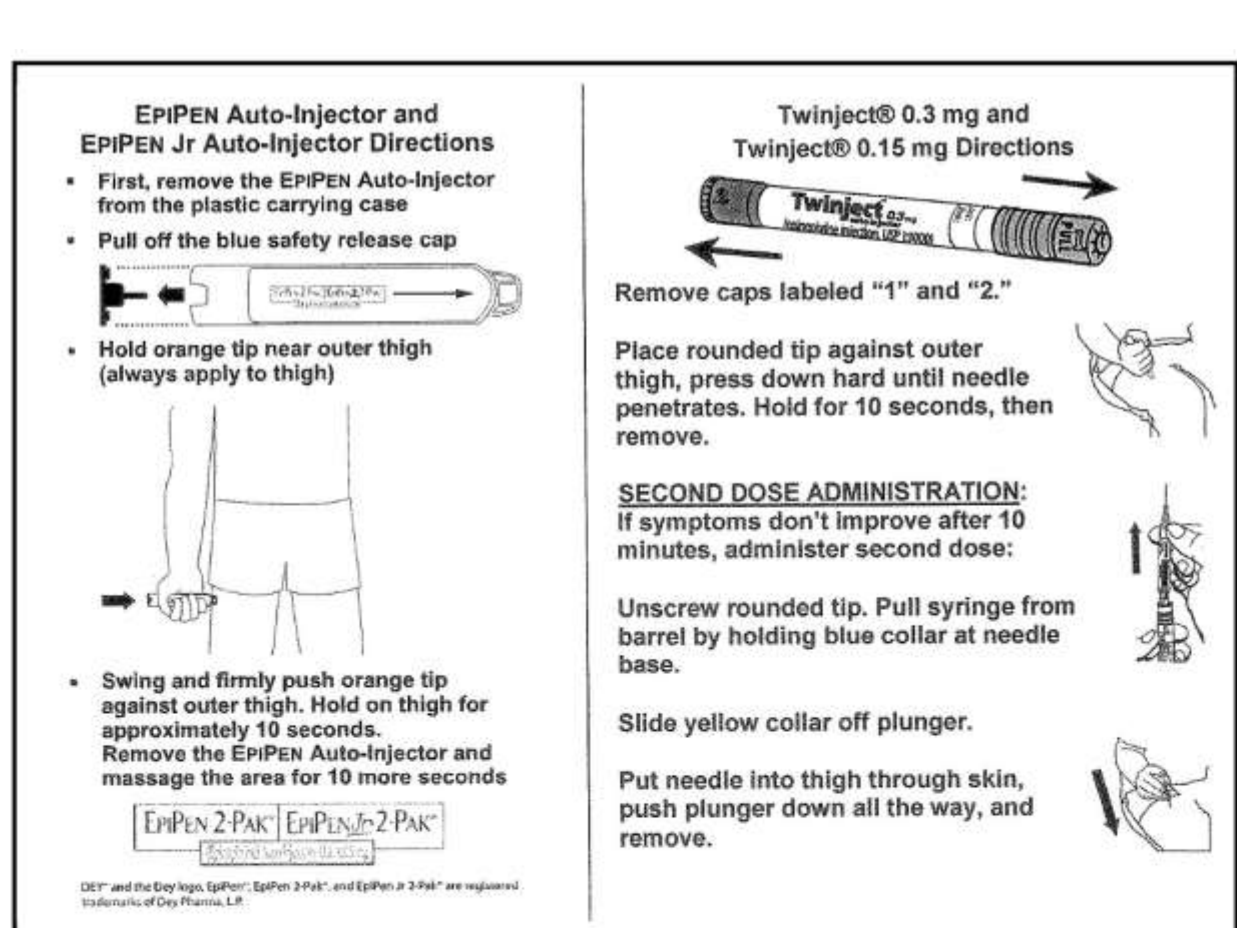
♦Step 2: EMERGENCY CALLS♦

1. Call 911 if epinephrine given. State than an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Parent.

EVEN IF PARENT CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!!

Parent/Guardian's Signature ________________________________ Date __________

Doctor's Signature ____ Date __________
(Required)



Once EpiPen® Twinject® is used, call the Rescue Squad. Take the used unit with you to the ER. Plan to stay for observation at ER for at least 4 hours.

This form was modeled after the Food Allergy and Anaphylaxis Network action plan.