TUPELO PUBLIC SCHOOL DISTRICT

Allergic Reaction Care Plan

Information will be shared with appropriate school staff for your child's best care.

Use separate form for each allergy

*Healthcare provider signature required

Student	Parent/Legal Guardian
Date of Birth	Home phone
School School Year	Work phone
Bus_____ Car rider_____ Walker_____	Cell phone
Teacher Grade	Emergency contact:
	Phone#

ALLERGIC TO_____

€ *Latex* € *Beestings - wasps – mosquitoes* € *Food (name each food)* € *Other*

Child is allergic to _____ Will your child need medication regardless of symptoms? Yes ____ No____

Does your child have asthma? □ No □ Yes, at risk for severe reaction

For these symptoms	**Give: doctor please indicate**
▶ *no symptoms*	□ Epinephrine □ Antihistamine
▶ **Mouth** -itches, tingles, or swells in the lips or tongue	□ Epinephrine □ Antihistamine
▶ **Skin** -develops hives, itchy rash, swelling of arms and /or legs	□ Epinephrine □ Antihistamine
▶ **Abdomen**- Nausea, abdominal cramps, vomiting, diarrhea	□ Epinephrine □ Antihistamine
▶ **Throat** -Tightening of throat, hoarseness, hacking, repetitive cough *	□ Epinephrine □ Antihistamine
▶ **Lungs** -Shortness of breath or wheezing *	□ Epinephrine □ Antihistamine
▶ **Heart** -Weak pulse, fainting, pale or blue color to skin *	□ Epinephrine □ Antihistamine
* ***Indicates very serious- call 911 Immediately***	***Anaphylaxis can happen at any time***
DO NOT HESITATE TO CALL 911 DO NOT HESITATE TO GIVE MEDICATION	*If Antihistamine is given, call parent/legal guardian* *If Epinephrine auto-injector is used, call 911*

*What is your child's most usual sign/symptom during the allergic reaction? ___local swelling ____hives ____trouble breathing ____ full faint, collapse "anaphylaxis" other*_____

_____

This care plan serves as medication permission form when signed by healthcare provider and parent/legal guardian.

Pediatric Dose - *Healthcare provider to fill out*	**Adult dose - *Healthcare provider to fill out***
Benadryl 12.5 mg __tsp __tablet __gel capsule	Benadryl 25 mg __tsp __tablet __gel capsule
Epi Pen 0.15 mg auto-injector (# of pens_____)	Epi Pen .3 mg auto-injector (# of pens_____)
Twin-ject 0.15 mg auto-injector (# of pens_____)	Twin-ject .3 mg auto-injector (# of pens_____)
€	€
LOCATION OF MEDICATION_____ **Date of Expiration:**_____	*All auto-injector epinephrine is given IM (intra-muscularly).* *Asthma inhalers do not replace auto-injector epinephrine.*

Healthcare Provider: Complete for Student who will self medicate

- € Student has been instructed in proper use/care of his/her medication
- € It is my professional medical opinion that he/she **be allowed** to carry/store/this medication by him/herself
- € It is my professional medical opinion that he/she **not be allowed** to carry/store this medication by him/herself

Special instructions:

_____

_____

Healthcare Provider Signature

_____ Date_____

Phone_____ FAX_____

Parent/Legal Guardian Signature

_____ Date_____

Daytime Phone_____

School Nurse_____ Date_____