Brandon Valley School District
Health Services

Allergy Health Care Plan

Students Name: _____ Birthdate: ___/___/___ Bus: □ Yes □ No

School: _____ Teacher: _____ Grade: _____

Parent/Guardian: _____ Phone: _____

_____ Phone: _____

Emergency Contact: 1) _____ Phone: _____

2) _____ Phone: _____

Physician: _____ Phone/Fax: _____/_____

Preferred Hospital: _____

ALLERGIC TO:

History of Asthma: □ Yes * □ No History of Anaphylaxis: □ Yes * □ No (*higher risk for severe reaction)

Describe History: _____

TO BE COMPLETED BY PHYSICIAN:

If Student Has These Symptoms: •Potentially life threatening. The severity of the symptoms can change quickly.	**Give Checked Medication or Observation:** (to be determined by the physician authorizing treatment)
Mouth: itching, tingling or swelling of lips, tongue, mouth	□ Epinephrine □ Antihistamine □ Observation
Skin: Hives, itchy rash, swelling of the face or extremities	□ Epinephrine □ Antihistamine □ Observation
GI: Nausea, abdominal cramps, vomiting, diarrhea	□ Epinephrine □ Antihistamine □ Observation
Throat:* tightening of throat, hoarseness, hacking cough	□ Epinephrine □ Antihistamine □ Observation
Lung:* Shortness of breath, repetitive cough, wheezing	□ Epinephrine □ Antihistamine □ Observation
Heart:* Weak, thready pulse, low blood pressure, fainting, pale, blueness	□ Epinephrine □ Antihistamine □ Observation
Other:*	□ Epinephrine □ Antihistamine □ Observation

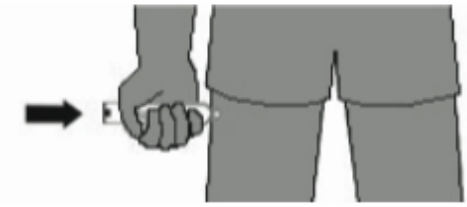
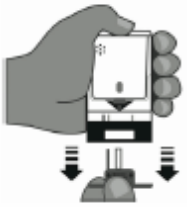
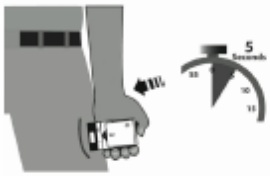
The following to be determined by the physician authorizing treatment:

EPINEPHRINE TYPE and DOSE:
□ EpiPenJr. (0.15mg) □ EpiPen (0.3mg)
□ AuviQ(0.15mg) □ AuviQ (0.3mg)

May self-carry medication: □ Yes □ No

ANTIHISTAMINE TYPE and DOSE:
□ Benadryl (also known as Diphenhydramine)
□ 12.5mg (1 teaspoon or 1 chewable)
□ 25mg (2 teaspoon or 2 chewable or 1 tab)
□ 50mg (4 teaspoon or 4 chewable or 2 tab)
□ Other Antihistamine_____

X_____ _____ **X**_____ _____
Physician Signature Date Parent/Guardian Signature Date

EpiPen Auto-Injector and EpiPen Jr Auto-Injector Directions	Auvi-Q 0.3mg and Auvi-Q 0.15mg Directions
1) First Remove the EpiPen Auto–Injector from the plastic carrying case.  2) Pull of safety release cap. 3) Hold tip near outer thigh (always apply to thigh)  4) Swing and firmly push tip against outer thigh. Hold on thigh for approximately 10 seconds. 5) Remove the EpiPen Auto-Injector and massage the area for 10 more seconds.	1) Remove the outer case of Auvi-Q. This will automatically acitvate the voice instructions. 2) Pull of RED safety guard.  3) Place black end against outer thigh, then press firmly and hold for 5 second. 

*** 911 will be activated and student will be transported to hospital. If symptoms have not improved within 10-15 minutes after 1st Epipen injection, administer a 2nd Epipen if available.**

*EpiPens are kept in the nurse's office. If a student is carrying a second set of EpiPens in their backpack, please notify the nurse. Emergency medications will be sent on all field trips for elementary and middle school. High school staff will be responsible for carrying student epinephrine on field trips unless the student carries their own.

*A **"Consent and Request for Medication during School Day" Form** must be completed and kept on file in the school health office. Parents are responsible for providing all new health forms, including this Health Care Plan, by the first day of each school year. Any updates throughout the school year should be submitted to the School Nurse.

***If your child is on a Special Diet for food allergies, please obtain this form from the Brandon Valley School District Child Nutrition Dept.**

** This information will become part of your child's confidential permanent record. If for any reason you do not wish to respond to part of this form you are under no obligation to do so. Please understand that we are not responsible for injury or illness that may be a result of these omissions.*

By signing below I understand that I am giving my permission to share this information with school staff/trained personnel as needed with strict confidentiality maintained by all. I also give my permission for the school nurse to contact the Primary Care Physician or Allergist if further information is needed.

Parent Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____