East Allen County Schools
HEALTH SERVICES
Individual Health Care Plan (IHP)--*Allergic Reaction*

STUDENT NAME:_____ Birth Date:_____ Grade:_____

ALLERGIC TO: _____ ASTHMATIC: ☐ NO ☐ YES...Higher risk of severe reaction

STEP 1: *TREATMENT* (*must be completed by physician*)

Symptoms:		Give Checked Medication:
▪ If allergen ingested or stung by insect, but *no symptoms*		☐ Epinephrine ☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of the lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ Stomach	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ Throat †	Tightening of the throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ Lung †	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ Heart †	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other †	_____	☐ Epinephrine ☐ Antihistamine
▪ If the reaction is progressing (several of the above areas affected), give		☐ Epinephrine ☐ Antihistamine

† Severity of symptoms may quickly progress to a potentially life threatening situation.

Medication Dosage (*must completed by physician*):

Epinephrine: inject intramuscularly **Auvi-Q / EpiPen / EpiPen Jr.** Expiration Date: _____
(Circle one)

Antihistamine: give _____
(**PRINT**....Medication / dose / route)

Other: give _____
(**PRINT**....Medication / dose / route)

Student trained to self-administer ☐ NO ☐ YES Student must carry auto injector ☐ NO ☐ YES

STEP 2: *EMERGENCY CALLS……*

- **CALL 911 IF** ☐ **Epinephrine given** ☐ **Antihistamine given**
  Inform 911 severe allergic reaction has been treated, additional epinephrine may be needed.
  Hospital Preference: _____
- **CALL Parent:**

  Mother: _____ Daytime Phone: _____ Cell: _____

  Father: _____ Daytime Phone: _____ Cell: _____

IF parent cannot be reached, DO NOT hesitate to treat and transport.

- **CALL Doctor:** _____ Office Number: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

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ADDITIONAL INSTRUCTIONS NOTED ON BACK

TRANSPORTATION

Student should sit at front of bus	☐ Not necessary	☐ YES
Individual Health Care Plan--*Allergic Reaction* needed on bus	☐ Not necessary	☐ YES
Emergency medication needed on the bus?	☐ Not necessary	☐ YES

FIELD TRIP ACCOMODATIONS

Emergency medication MUST accompany student during any off campus activities	☐ Not necessary	☐ YES
Parent or designated family member will accompany student on field trips	☐ Not necessary	☐ YES

Other _____

CLASSROOM ☐ No accommodations needed ☐ YES accommodations needed

_____

STUDENTS WITH SEVERE FOOD ALLERGIES

This student requires dietary accommodations at school ☐ Not necessary ☐ YES accommodations needed

Dietary accommodations _____

_____

ALL medication must be supplied to the school by the parent/legal guardian. **If no emergency medication is supplied to the school, this student will be immediately transported to the nearest hospital for treatment.**

It is the parent's responsibility to keep the school informed, in writing, of any changes to this care plan. If a care plan for the current school year is not provided to the school, the most recent care plan available to the school will be followed.

This Allergic Reaction IHP may be shared with appropriate staff on a need to know basis.

Parent gives permission to contact health care provider if necessary.

Parent gives the school permission to take a picture ID of this student.

Parent/Legal Guardian Signature _____ Date _____

Health Care Provider's Signature - REQUIRED

_____ Office Phone _____ Date _____

_____
Health Care Provider's name PRINTED

ATTACHMENTS:
Hs-5 Medication Permit
Hs-5b Medication Self-Administration Consent Form
Authorization to Provide Emergency Medical Care by Trained School Personnel