NWSC HEALTH SERVICES
Severe Allergies (Anaphylaxis)
Individual Health Plan (IHP)

STUDENT INFORMATION:
Name:_____
Date of Birth:_____ **Grade/Teacher:**_____

Health Care Provider to Complete
Specify Allergen:
☐ Bee stings
☐ Nuts, Specify:_____
☐ Other, Specify:_____

Asthmatic: Yes *_____ No_____ *High risk for severe reaction

Parent to Complete

Parent / Guardian:			
Mother's phone	Home:	Work:	Cell:
Father's phone	Home:	Work:	Cell:
Health Care Provider:		Phone:	Fax:
Brief history of diagnosis:			
Recent hospitalizations:			
Concurrent illness or disability:			

Signs and Symptoms of an Allergic Reaction	
Mental	**States feels "scared"; something bad is going to happen**
Mouth	**Itching and swelling of lips, tongue, or mouth**
Throat	**Itching and/or sense of tightness in throat, hoarseness, hacking cough**
Skin	**Hives, itching rash and/or swelling about the face or extremities**
Abdomen	**Nausea, abdominal cramps, vomiting and/or diarrhea**
Lungs	**Shortness of breath, repetitive coughing and/or wheezing**
Heart	**Weak, rapid, irregular pulse, "passing out"**

Severity of symptoms can change quickly, and rapidly progress to a life-threatening situation!

NEVER SEND STUDENT WITH ANY ALLERGIC SYMPTOMS ANYWHERE ALONE

Please indicate if condition is life threatening:

☐ **No**, this condition is not life threatening. No intervention is needed at this time.
(Thank you for your time. Please sign on back page.)

☐ **Yes**, this is a life threatening condition. A medication/treatment plan is needed.
(Continue on back page)

ACTION FOR MINOR REACTION

1. If only symptom(s) are:_____
Give: (medication/dose/route)_____

2. Then call:
   - ✓ Mother:_____,Father_____
   - ✓ Doctor_____at_____

(If condition does not improve, follow steps for Major Reaction below)

ACTION FOR MAJOR REACTION

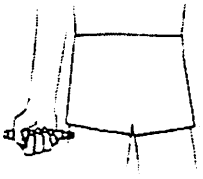
1. If ingestion is suspected and/or symptoms are:_____
Give: (medication/dose/route)_____

2. Then call:
   - ✓ Rescue Squad 911 (ask for advanced life support)
   - ✓ Mother_____,Father_____
   - ✓ Doctor._____at_____
   - ✓ Emergency Contacts (if parents cannot be reached)
     1._____Phone:_____
     2._____Phone:_____

EpiPen® and EpiPen® Jr. Directions

- **Pull off gray activation cap.**

- **Hold black tip near outer thigh (always apply to thigh).**



- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

Classroom Information/Accommodations (as needed):

- parents to provide all classroom snacks for the year
- other_____

School Bus Driver Instructions (as needed):

_____
_____
_____
_____

Field Trip Accommodations (as needed):

- All medications/supplies are taken and care is provided (Mark one)
  - ☐ By accompanying parent
  - ☐ By the student, if self - managing
  - ☐ By accompanying designated school staff per district medication policies and orders

Extra-Curricular Activities Accommodations (as needed):

- All medications/supplies are taken and care is provided (Mark one)
  - ☐ By accompanying parent
  - ☐ By the student, if self - managing
  - ☐ By accompanying designated school staff per district medication policies and orders

Disaster Planning:

_____
_____
_____
_____

- **I give the Licensed School Nurse permission to consult (both verbally and in writing) with the above named student's physician regarding any questions that arise about the medical condition and/or medications/treatments/procedures being used to treat the condition**

_____yes _____no

Parent signature_____Date:_____
Physician signature*_____Date:_____
School Nurse_____Date:_____
*Needed only if this form is used as a doctor's medication or treatment order