PLYMOUTH JOINT SCHOOL DISTRICT – CONFIDENTIAL HEALTH INFORMATION
Student Health Services

School Year _____ **SEVERE ALLERGY HEALTH ACTION PLAN**

Student Name _____

Date Of Birth _____ Grade _____ Grad Year _____
School _____ Teacher/ HR _____

PARENT / GUARDIAN EMERGENCY CONTACT INFORMATION:
Please provide phone numbers in order of where we can best reach you during the school day in case of emergency

Phone 1. _____ H/C/W Name/ Relationship _____
Phone 2. _____ H/C/W Name/ Relationship _____
Phone 3. _____ H/C/W Name/ Relationship _____
Phone 4. _____ H/C/W Name/ Relationship _____
Address for Health Plan updates:_____
Email for Health Plan updates: _____

ALLERGY:_____

Physician student sees for Allergy _____ Phone _____

Asthmatic: Yes ___ No ___ (If yes, student has higher risk for a severe reaction)

Check the symptoms your child has during a severe allergic reaction:

❑ Hives / rash	❑ Tightness in Chest	❑ Difficulty Breathing	❑ Nausea and vomiting
❑ Itching	❑ Swelling at the site	❑ Unconsciousness	❑ Cramping and abdominal pain
❑ Dizziness	❑ Flushed face	❑ Hacking cough	❑ Swelling of lips, tongue, nose, throat or face
❑ Drooling	❑ Swelling of the extremities		
❑ Other _____			

Onset of Symptoms after ingestion or contact:
❑ Immediately ❑ Within 15 minutes ❑ Within an hour ❑ Within 2 hours ❑ Unknown or varies

Does your child require an antihistamine at school? Yes___ No___ Location: _____

Medication/Dose _____

Does your child require Epinephrine at School? Yes____ No____ Location: _____

Can your child self-administer epinephrine in school? Yes____ No____

Has your child ever needed epinephrine before? Yes___ No____
Explain: _____

For Staff Use

NOTE: Parents are responsible for providing medication given at school. A Medication Authorization Form needs to be filled out and signed by a parent/guardian and doctor annually.

PLEASE COMPLETE AND SIGN NEXT PAGE ➔

Student Name _____

EMERGENCY ACTION PLAN- STEPS TO TAKE DURING AN ALLERGIC REACTION

If you see this: Mild Reaction_____
Do This:

- Have student come to the office/health room with an escort
- Call parent / guardian to inform them of situation and get permission to give antihistamine (such as Benadryl)
  Give _____mg _____ antihistamine orally
- Locate the student's epinephrine pen or retrieve a STOCK EpiPen if theirs cannot be located
- Continue to monitor for 20-30 minutes and observe for signs and symptoms of **anaphylaxis (see below)**

IF YOU SEE THIS: ANAPHYLAXIS, A SEVERE ALLERGIC REACTION

Mouth: Itching, tingling or swelling of the lips, tongue, or mouth
Throat: Itching or tightening in the throat, hoarseness, hacking cough
Skin: Hives, itchy rash, swelling of the face or extremities
Gut: Nausea, abdominal cramps, vomiting, diarrhea
Lung: Shortness of breath, repetitive coughing, wheezing
Heart: Weak or irregular pulse, low blood pressure, faintness, pale, blue

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DO THIS: FOR SEVERE ANAPHYLACTIC REACTION

- **Call the school office to have the EpiPen brought to student immediately**
- **Have the office call a Code Blue and CALL 911**
- **If the student does not have their EpiPen at school, use a STOCK EpiPen**
- **Administer the EpiPen immediately. May repeat with a second EpiPen after 5-20 minutes**
  - ☑ Dispose of needle and injector in a red sharps container
  - ☑ Give EpiPen package and a copy of this Health Plan to rescue personnel
- Notify parent / guardian (EpiPen administration and calling 911 take priority over parent notification)
- Notify building principal and school nurse, if not already aware
- Complete an Accident/Incident Report and Code Blue Report form

Memo of Understanding:

- It is understood that a parent will complete and sign an Allergy Health Action Plan annually.
- It is understood that a parent will provide emergency medications needed at school.
- It is the responsibility of the parent to notify the nurse of any changes in the health plan.

This plan and medication will be used in case of emergency and accompany student off school property. This information may be shared with the classroom teacher(s), administrators, aides, bus driver, and other appropriate school personnel with a need to know.

Parent/Guardian Signature: _____ Date _____

School Nurse: _____ Sara Stout, RN or Anne Nelson, RN

Health Care Provider Signature: _____ Date _____
(if necessary)