Maine Township High School
Allergy Health Care Plan

Student's Name: ____ D.O.B.: ______________ ID #: _________________

Allergy To: ____

Asthma Yes* ☐ No ☐ *Higher Risk for severe reaction Weight: ________lbs

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

Lung: Shortness of Breath, Wheezing, Repetitive Cough
Heart: Pale, Blue, Faint, Weak Pulse, Dizzy, Confused
Throat: Tight, hoarse, trouble breathing/swallowing
Mouth: Obstructive swelling (tongue)
Skin: Many hives over body

Or Combination of symptoms from different body areas:

Skin: Hives, itchy rashes, swelling
Gut: Vomiting, cramping pain

- **INJECT EPINEPHRINE IMMEDIATELY**
- Call 911
- Notify School Nurse
- Monitor Student
- Give Antihistamine per order
- Use Inhaler per order (if asthma)
- Nurse/Designee will notify Parent/Guardian
- Student will be transported to hospital

☐ If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.
☐ If checked, give epinephrine before symptoms if the allergen was definitely eaten.

MILD SYMPTOMS ONLY

Mouth: Itchy Mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort

- **GIVE ANTIHISTAMINE**
- Stay with student and monitor
- Notify parent

If Symptoms Progress (see above), Inject Epinephrine

Medications/Doses

Epinephrine (Brand and Dose) ________________________________
Antihistamine (Brand and Dose) ________________________________
Other (e.g., inhaler-if asthma) ________________________________

Location of Medication

☐ Student to carry
☐ Health Office
☐ Other: _____________________

Authorization and Permission for Administration of Medication Form must accompany this Health Care Plan

Emergency Contacts:

Parent/Guardian: ____ Phone: ______________________________

Name/Relationship: ______________________________________ Phone: ______________________________

Trained Staff Members

Name: Brenda Lynch, RN, IL CSN ____________________ Name: ____________________________________
Name: Peggy Kendrick, RN ____________________

____ ________________________ ________________
Licensed Health Care Provider Signature ***Phone*** ***Date***

____ ________________________
Parent/Guardian Signature ***Date***