Delaware Valley Regional High School

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SEVERE ALLERGY/EMERGENCY HEALTH CARE PLAN

Student Name: _____ **DOB:** _____ **Class of 20**_____

School Year: _____ **Allergies:**_____

Asthmatic Yes* ☐ No ☐ *If yes there is a high risk for severe reaction

The student may self-administer_____ Yes ☐ No ☐

Symptoms	**Give Checked Medication**** (To be determined by physician authorizing treatment)	
• If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine	☐ Antihistamine
• Mouth – Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
• Skin – Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
• Gut – Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
• Throat*** - Tightening of 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 reaction is progressing (several of the above areas affected)	☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. ***Potentially life-threatening.

Dosage

Epinephrine: inject intramuscularly_____
medication/dose

May repeat in _____ minutes **911 will be called if EpiPen is used.**

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

Name/Relationship	**Phone Number(s)**	
a. _____	1. _____	2. _____
b. _____	1. _____	2. _____
c. _____	1. _____	2. _____

❖ The certified school nurse may designate another employee of the district to administer a pre-filled dose auto-injector mechanism, containing epinephrine, when the school nurse is not physically present at the scene. I give my permission to share this information with appropriate Delaware Valley Regional High School Staff.

Permission to Self-Administer Medication:

☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is not approved to self-medicate.

Parent/Guardian Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____
(required)

Reviewed by School MD: _____ **Date:** _____

Revised 09/2017