|  |
| --- |
| Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_\_\_\_\_  DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Teacher/Hmrm\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School Year 20\_\_-20\_\_ |



Bloomington Schools Health Service

1350 West 106th Street

Bloomington, MN 55431-4126

Place

Child’s

Picture

Here

**SEVERE ALLERGY EMERGENCY HEALTH PLAN**

**ALLERGY TO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Asthmatic Yes ⁭ No ⁭ \*Students with asthma are at risk for more severe reaction.

* **SIGNS OF AN ALLERGIC REACTION**

**Systems: Symptoms:**

**MOUTH** Itching & swelling of the lips, tongue, or mouth

**THROAT\*** Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough

**SKIN** Hives, itchy rash, and/or swelling about the face or extremities

**GUT** Nausea, abdominal cramps, vomiting, and/or diarrhea

**LUNG\*** Shortness of breath, repetitive coughing, and/or wheezing

**HEART\*** “Thready” pulse, “passing-out”

**The severity of symptoms can quickly change.**

**\*All symptoms can potentially progress to a life-threatening situation.**

* ACTION FOR **MINOR REACTION**

1. If only symptom(s) are\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

medication/dose/route

Then call:

2. Parents/guardians or emergency contacts:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. If symptoms do not improve in 10 minutes, follow steps for MAJOR REACTION below.

* ACTION FOR **MAJOR REACTION**

1. If symptom(s) are: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give **EpiPen®** IMMEDIATELY

Location of Epi Pen: Classroom\_\_\_ Health office\_\_\_ Both\_\_\_

Then call:

2. Rescue 911 (ask for advanced life support)

3. Parent/guardian or emergency contacts.

4. Stay with student until paramedics arrive

***DO NOT HESITATE TO CALL FOR EMERGENCY HELP!***

FIELD TRIP PLAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EPIPEN® AND EPIPEN® JR. DIRECTIONS**

**1. Pull off gray safety cap**

**2. Place black tip on outer thigh (always apply to thigh)**

**Using a quick motion, press hard into thigh until Auto-Injector mechanism functins. Hold in place and count to 10. The EpiPen® unit should then be removed and discarded.**

**Massage the injectin area for 10 seconds.**

**CONTACTS:**

Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Home#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician/Clinic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital of choice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*I give Health Service Personnel permission to consult 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.**

**\*It is recommmended that the parent/guardian complete a transportation form from the bus company.**

Parent/Guardian signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Physician signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*(Only necessary if medication or treatment needed at school)

Health Service Personnel\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* We ask you to complee this form at the beginning of every school year to ensure we have the most current information on your child
* The school district intends to use the requested information to provide for you child’s health and safety while at school.
* You may refuse to supply the requested personal information. There will be no conequences for not providing the information.

It may result in an incomplete health plan for your child.

* The information your provide will be shared only with staff in the school district where jobs require access to this information to ensure your child’safety
* If we are unable to reach you or your designee during an emergency we will call 911 for assistance if needed.
* I give permission for the school health service staff to consult with my child’s physician about any questions regarding the listed medication(s) or medical condition(s) being treated,
* Please contact you school promptly with any changes of information on this form.

HS #1a 9//09