SUWANNEE COUNTY SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

SEVERE ALLERGY MEDICAL MANAGEMENT PLAN

Student Name: _____ DOB: _____ Grade: _____ Teacher: _____

Parent / Guardian: _____ Phone: _____

Physician / Provider: _____ Phone: _____

SEVERE ALLERGY TO: _____

Asthma: ☐ Yes ☐ No (Higher risk for severe reaction if asthmatic)

SYMPTOMS OF ANAPHYLAXIS

- Mouth – itching, swelling of lips and/or tongue
- Throat – itching, tightness/closure, hoarseness
- Skin – hives, itching, redness, and/or swelling
- Stomach – vomiting, diarrhea, cramps
- Lung – shortness of breath, coughing, wheezing
- Heart – weak pulse, dizziness, fainting

SYMPTOMS OF MILD REACTION

Mouth-itching
Skin-a few hives, itching
Stomach-nausea/discomfort

***Only a few symptoms may be present. Severity of symptoms can change quickly. Some symptoms can be life-threatening.**

EMERGENCY MEDICATIONS: **Authorization form must be filled out if medications needed**

☐ **Epinephrine:** Administer initial dose (as ordered) with onset of symptoms.

Specify instructions _____

Location of epinephrine/meds: ☐ School Clinic ☐ Carried by Student **Student may self-administer: ☐ Yes ☐ No

☐ **Antihistamine:** Specify directions _____

☐ **Rescue Inhaler:** Specify directions _____

☐ Treatment of mild reaction: give antihistamine first. If symptoms progress to severe: give epinephrine

☐ **Other:** _____

_____

_____

Medications must go with student on field trips

MANAGEMENT OF ANAPHYLAXIS

1. **INJECT EPINEPHRINE IMMEDIATELY** (Note time when administered.)
2. **Call 911 IMMEDIATELY**
3. Notify Parent
4. Do not leave student alone, continue to monitor

_____ _____
Physician/Provider Signature (Required) Date

_____ _____
Parent/Guardian Signature (Required) Date

_____ _____
School Nurse Signature Date