

Fayette County School Health Services
SEVERE ALLERGY HEALTH CARE PLAN

Please bring or mail this health care plan to the school or send to the secure FAX at 770-460-3928.

ALLERGY TO: _____ **Asthmatic** **Yes** **No**

Student: _____ **Birth Date:** _____ **School Year: 20** ____ **- 20** ____

School: _____ **Homeroom Teacher:** _____ **Grade/Team:** _____

STEP 1: TREATMENT

SYMPTOMS:

NO SYMPTOMS, but ingested or in contact with allergen
MOUTH: Itching, tingling, or swelling of lips, tongue, mouth
SKIN: Hives, itchy rash, swelling of the face or extremities
GUT: Nausea, abdominal cramps, vomiting, diarrhea
THROAT+: Tightening of throat, hoarseness, hacking cough
LUNG+: Shortness of breath, repetitive coughing, wheezing
HEART+: Thready pulse, low blood pressure, fainting, pale, blueness
OTHER: _____
SEVERAL of the above areas affected and reaction progressing
+ Potentially life-threatening symptoms.

Give Checked Medication:

Epinephrine Antihistamine
 Epinephrine Antihistamine
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 Epinephrine Antihistamine
 Epinephrine Antihistamine
 Epinephrine Antihistamine

MEDICATIONS:

	<i>Medication Name/Dose/Route</i>
Epinephrine inject intramuscularly	<input type="checkbox"/> EpiPen® <input type="checkbox"/> EpiPen Jr.® <input type="checkbox"/> Twinject™ 0.3mg <input type="checkbox"/> Twinject™ 0.15mg
Antihistamine orally	
Other	

Student may carry and self-administer Epinephrine due to Severe Allergy: **Yes** **No**

STEP 2: EMERGENCY CALLS

1. **Call 911** (Emergency Medical Services) immediately. State that an allergic reaction has been treated.
2. **Call Dr.** _____ at _____.

3. Call Emergency Contacts:

<i>Parent/Guardian/Contact</i>	<i>Relationship</i>	<i>Phone Number</i>	<i>Alternate Phone Number</i>

DO NOT HESITATE TO MEDICATE OR CALL EMS even if Parents or Physician CANNOT be reached.

Physician's Signature: _____ **Date:** _____

Physician's Name: _____ **Telephone Number:** _____

I, this child's parent/guardian, hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's severe allergy and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Fayette County Schools. This authorization expires as of the last day of the school year.

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

EpiPen® and EpiPen Jr.® Directions

- Pull off gray activation cap.



- Hold back tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg - Twinject™ 0.15 mg Directions

- Pull off green end cap, then red end cap.



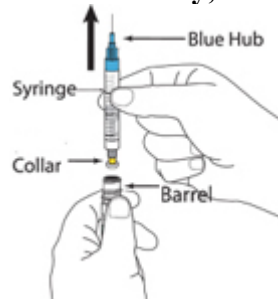
- Put gray cap against outer thigh, press down firmly until need penetrates. Hold for 10 seconds, then remove.



SECOND DOSE ADMINISTRATION:

If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew gray cap and remove syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.



Once EpiPen® or Twinject™ is used, call EMS. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

EpiPen and Twinject Directions adapted from The Food Allergy & Anaphylaxis Network.

STAFF TRAINING RECORD

<i>Date</i>	<i>Staff's Name</i>	<i>Training</i>	<i>Trainer's Signature</i>

Implemented: August

Revised: February 6, 2002; May 2003; August 2, 2004; March 7, 2006