Date Plan was Developed:_____

TAMARAK COUNTRY SCHOOL

SEVERE ALLERGY CARE PLAN
(Must be completed by a licensed health professional)

NAME	Severe ALLERGY to:

Other allergies:

Class	Birthdate	Routine medications (at home/school)

Asthmatic? (High risk for severe reaction): ☐ Yes ☐ No

Date of last reaction:

Please list the specific symptoms the student has experienced in the past:

Location(s) where Epi-pen/Rescue medications is/are stored:
☐ Office ☐ Backpack ☐ On Student ☐ Teacher ☐ Other_____

ACTION PLAN

If you suspect a severe allergic reaction to bees or food, immediately determine the symptoms and treat the reaction as follows:

Symptoms (known symptoms 'X')		Give Medication (X)	
☐ MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth	☐ Antihistamine	☐ Epipen
☐ SKIN	Hives, itchy rash, and/or swelling about the face or extremities	☐ Antihistamine	☐ Epipen
☐ THROAT	Sense of tightness in the throat, hoarseness and hacking cough	☐ Antihistamine	☐ Epipen
☐ GUT	Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea	☐ Antihistamine	☐ Epipen
☐ LUNG	Shortness of breath, repetitive coughing, and/or wheezing	☐ Antihistamine	☐ Epipen
☐ HEART	"Thready" pulse, "passing out", fainting, blueness, pale	☐ Antihistamine	☐ Epipen
☐ GENERAL	Panic, sudden fatigue, chills, fear of impeding doom	☐ Antihistamine	☐ Epipen
☐ OTHER	_____	☐ Antihistamine	☐ Epipen
◆ If a **food allergen** has been ingested, but no symptoms: Other: _____		☐ Antihistamine	☐ Epipen
◆ If exposure to allergen other than by ingestion (i.e., skin, inhalation)		☐ Antihistamine	☐ Epipen
◆ If a reaction is progressing (several of the above areas affected)		☐ Antihistamine	☐ Epipen

◆ **Asthma?** ☐ Yes ☐ No

◆ If **only** lung symptoms are present without known triggers of asthma or suspected ingestion first give: ☐ Fast acting inhaler ☐ Antihistamine ☐ Epipen

◆ If only inhaler is given and lung symptoms are not relieved within minutes ☐ Repeat inhaler ☐ Antihistamine ☐ Epipen

911 must be called if Epipen is administered.

Medication Doses

Antihistamine _____	Dose: _____**Teaspoons** _____**Tablets by mouth**
Epipen (.03) ☐ Epipen Jr. (0.15) ☐	Side Effects:
Repeat dose of Epipen: ☐ Yes ☐ No	If YES, when

◆ **DO NOT HESITATE to administer Epipen and to call 911 even if the parents cannot be reached.**

	Start Date:	**End Date:**
Licensed Health Professional's Signature	Today's Date:	
	Phone:	
Licensed Health Professional's Printed Name	Fax Number:	

Licensed Health Professional (LHP) Orders / Care Plan for Severe Allergy – Part 2

- Student should remain quiet with a staff member until EMS arrives.
- Notify the administrator and parent/guardian.
- Provide a copy of the Emergency Care Plan to EMS upon arrival.

Individual Considerations

Van –Transportation will be alerted to student's allergy. (Kindergarten Enrichment Students)

- This student carries Epipen on the bus ☐ Yes ☐ No
- Epipen can be found in: ☐ Backpack ☐ Waistpack ☐ Other_____
- Other consideration _____

Field Trip Procedures – Epipen & allergy plan will accompany student during any off campus activities.

- The student should remain with the teacher during the entire field trip ☐ Yes ☐ No
- Other _____
- Staff members on trip will be trained regarding Epipen use and this health care plan.

LUNCH BUNCH (for students with food allergies)

☐ Student will sit at a specified allergy table.

This student is allowed to eat only the following foods:

☐ School snacks approved by parent. (see snack list)

☐ Alternative snacks will be provided by parent/guardian to be kept:

☐ with the teacher.(location) _____. ☐_____.

☐ Those in manufacturer's packaging with ingredients listed and determined allergen-free by the teacher/parent or _____

☐ **NO Restrictions**

SCHOOL ACTIVITIES (for students with food allergies)

☐ School projects should be reviewed by the teaching staff to avoid specified allergens.

EMERGENCY CONTACTS

Mother/Guardian	
	Name
	Home Phone
	Work Phone
	Other

Father/Guardian	
	Name
	Home Phone
	Work Phone
	Other

ADDITIONAL EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:

Parent signature gives permission for school staff, that have been medication trained by medical personnel or parent, to administer prescribed medicine and gives permission to contact physician, if necessary.

Parent/Guardian Signature Date

TCS Teacher Signature Date

A copy of the Health Care Plan will be kept in the office and available to all staff members who are involved with the student.