Fulton County Schools
Where Students Come First

Student Health Services

Allergy Care Plan

Student's Name _____ D.O.B_____ Teacher_____
School_____Grade_____ (*Please attach picture to Care Plan)

ALLERGY TO: _____

□ ***Box checked indicates a severe allergy which may lead to anaphylaxis.***
Asthmatic Yes*□ No □ *Higher risk of severe reaction *Inhaler at school? Yes___ No ___ Carries___

STEP 1: TREATMENT

Symptoms:	Give Checked Medication**: (**To be determined by physician authorizing treatment)
If an allergen has been exposed, 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

*** Allergies are potentially life-threatening. The severity of symptoms can quickly change.**

EMERGENCY MEDICATION DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg
(see reverse side for administration instructions)_____

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace Epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

1. Call 911 or Rescue Squad: _____.
*State that an allergic reaction has been treated and additional Epinephrine may be needed.
2. Dr's full name: _____ Office Phone:_____
3. Emergency contacts: Name/Relationship Phone Number(s)
a. _____ 1._____ 2. _____
b. _____ 1._____ 2. _____
c. _____ 1._____ 2) _____
Parent/Guardian Signature_____Date_____
Physician's Name (*print legibly*) _____Signature_____Date_____
(Physician's signature required)
Received Date: _____Cluster Nurse Signature/Special Education Nurse: _____

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