Individualized Healthcare Plan(IHP)/Emergency Action Plan(EAP) for Student with History of Anaphylaxis

Name _____Date of Birth:_____

Parent/Guardian _____

Phone(w)_____(h)_____(c) _____

Physician_____Phone_____
Fax_____

ALLERGY TO (Please Be Specific)

_____

_____

Please list any major life activity limitations, if any

_____

_____

Date of last anaphylaxis episode and treatment required_____

_____

Health issues other than anaphylaxis_____

Asthma_____Yes _____No

Current medications, if any _____

_____

SYMPTOMS OF ANAPHYLAXIS INCLUDE

MOUTH	itching, swelling of lips and/or tongue
THROAT	itching, tightness/closure, hoarseness
SKIN	itching, hives, redness, swelling
GUT	vomiting, diarrhea, cramps
LUNG	shortness of breath, cough, wheeze
HEART	weak pulse, dizziness, passing out

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

EMERGENCY PLAN

1. INJECT EPINEPHRINE IN THIGH USING (check one)
    a. ____EpiPen Jr (0.15 mg)
    b. ____EpiPen (0.3 mg)
    c. _____Auvi-Q
    d. Other medication/dose/route _____
2. CALL 911
3. Emergency contact #1 _____
4. Emergency contact #2 _____

SPECIAL INSTRUCTIONS/ COMMENTS _____
_____
_____

Physician Consent for Anaphylaxis Emergency IHP

I have reviewed and approved this anaphylaxis emergency plan and included any recommended modifications. This consent is for a maximum of one year. If changes in procedure are indicated, I will provide written orders accordingly.
I have instructed this student in the proper use of his/her medications and he/she

- ☐ should be allowed to carry and use epipen by himself/herself. (event will be reported immediately to the school nurse)
- ☐ should keep the epipen in the school nurse's office

_____
Physician's Signature Date

Parent Consent for Anaphylaxis Emergency IHP

I, as parent/guardian, concur with the above anaphylaxis emergency plan, and will provide the necessary supplies and equipment, notify the school nurse if there is any change in our child's health status or doctor's orders, authorize the school nurse to contact the physician when necessary, and release the school district and its employees from any liability for any injury arising from my student's self-administration of prescription anaphylaxis medication while at school or a school-related event.

_____
Parent's Signature Date