



ALLERGY CARE PLAN

Date: ____/____/____
mm / dd / yyyy

Name of Student: _____
Last
First
Middle

Sex: M / F (*circle*)

Date of Birth: ____/____/____
mm / dd / yyyy

Grade: _____

SEVERE ALLERGY TO:

Asthmatic? Yes No *If Yes, increased risk for severe reaction.*

STEP 1: SIGNS & SYMPTOMS OF AN ALLERGIC REACTION – GIVE MEDICATIONS			
<u>If student has these Symptoms:</u>		<u>Give these Medications</u>	
		Antihistamine	Epinephrine
Mouth	Itching, tingling, or mild swelling of the lips	<input type="checkbox"/>	<input type="checkbox"/>
Skin	Mild hives, itchy rash	<input type="checkbox"/>	<input type="checkbox"/>
Skin	Mild hives, itchy rash unresponsive to antihistamine after 20 minutes	<input type="checkbox"/>	<input type="checkbox"/>
Skin	Severe hives, swelling of face or extremities	<input type="checkbox"/>	<input type="checkbox"/>
Gut	Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Throat	Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/>	<input type="checkbox"/>
Lung	Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Heart	Thready pulse, low blood pressure, fainting, pale	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamine to give: _____ <i>Medication / dose / route</i>			
Epinephrine to give: _____ <i>Medication / dose / route</i>			
Medication is located: _____			
Primary Care Provider/Physician, please check medication boxes above, and sign here:			
Name: _____ Signature: _____ Date: _____			

STEP 2:	EMERGENCY TRANSPORT & CALLS <i>Due to the lack of an Emergency Medical System (911) in Kathmandu, Lincoln School will initiate transportation of the student to a hospital emergency room (Norvic Hospital or Patan Hospital depending on traffic).</i>		
1. Call for and initiate transportation: Ambulance or school vehicle attended by driver AND adult with mobile phone AND at least 2 adults trained in CPR and epinephrine administration. Take CPR/AED equipment and epinephrine.			
2. Call Parent/Guardian/Emergency Contact			
Name of Parent/Guardian:			
a.	Home:	Work phone:	Mobile:
b.	Home:	Work phone:	Mobile:
Name of Emergency Contact:			
a.	Home:	Work phone:	Mobile:
b.	Home:	Work phone:	Mobile:

Name of Student: _____

Date: ____ / ____ / ____
mm / dd / yyyy

Other health concerns:	
Additional medications:	Dose & Time:
Dietary concerns/restrictions:	

ALLERGY HEALTH CARE PLAN MEDICATION AUTHORIZATION

Parent signature:	Date:
Parent name:	

Physician signature:	Date:
Physician name:	

EMERGENCY CONTACT INFORMATION

Name of Parent/Guardian:			
1.	Home:	Work phone:	Mobile:
2.	Home:	Work phone:	Mobile:

Emergency Contacts:			
1.	Home:	Work phone:	Mobile:
2.	Home:	Work phone:	Mobile:

Name of local physician:	Work phone:	Mobile:
Location of local physician:		

Name of local hospital:	Phone:	
Location of local hospital:		

Lincoln School Nurse: Marsha Dupar	School: 427 0482, 427 0603	Home: 446 0404	Mobile: 985 111 0959
Lincoln School Staff trained in administration of antihistamine and epinephrine:			