



**Severe Allergy Care Plan/
EPIPEN USE**

Student's Name: _____ Grade: _____

Severe Allergy to: _____

Reaction to the above: _____

Has student been hospitalized for this reaction: _____ If yes, date _____

Medications taken on a daily basis: _____

Are there diet restrictions? YES _____ NO _____

From the School Nurse: The "Severe Allergy Care Plan" is completed as a group effort and requires input from both the parent and the physician. Please note that this form does require a physician's signature. When I receive the completed form in my office, I will review it and share the information with your student's instructors.

Reminder: Faculty should carry EpiPen on all Field Trips. It should be kept at room temperature.

Mild symptoms of my student's allergy include the following: _____

Treatment for **mild symptoms** as listed above: _____

Severe Reactions may be life threatening and include:

Wheezing – Swelling (face, neck), tingling/ swelling of tongue – Vomiting – Shock – Loss of consciousness – Other _____

Treatment for life threatening reaction including symptoms listed above:

- EpiPen Jr. 0.15 mg**
- or
- EpiPen 0.3 MG**
 1. **Give immediately in outer thigh.**
 - Pull off gray cap**
 - Place black tip against outer thigh and press hard until unit clicks.**
 - Hold in place 10 seconds, then withdraw.**
 - Dispose of in impermeable can or, give to emergency provider.**
 2. **Call 911 or, take student to the nearest Emergency Room.**
 3. **Contact parent/guardian.**

I authorize student to have access to EpiPen:

Health Care Provider signature: _____ Date: _____

Parent/guardian signature: _____ Date: _____