JOHNSON CITY SCHOOLS - HEALTH SERVICES
INDIVIDUAL HEALTH PLAN (IHP) – CONFIDENTIAL

Severe Allergy (Anaphylaxis)

Student Information:

Name of Student: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Emergency Information:

Parent(s') Names: _____

Phone Number: _____ Phone Number: _____

Primary Care Physician: _____ Specialist: _____

Phone Number: _____ Phone Number: _____

Fax Number: _____ Fax Number: _____

In the event a parent/guardian cannot be reached:

Name: _____ Relation: _____ Phone Number: _____

Name: _____ Relation: _____ Phone Number: _____

Symptoms of Anaphylaxis Reaction	Using EpiPen
• Hives • Swelling of throat, lips, tongue, or around the eyes • Difficulty breathing or swallowing • Metallic taste or itching in the mouth • Generalized flushing, itching, or redness of skin • Abdominal cramps, nausea, vomiting or diarrhea • Increased heart rate • Sudden decrease in BP and accompanying paleness. • Sudden feeling of weakness • Anxiety of an overwhelming sense of doom • Collapse	• Form fist around carrier tube and remove PULL OFF BLUE SAFETEY CAP. • Remove EpiPen from the carrier tube (DO NOT but thumb, fingers or hand over orange tip.) • PLACE ORANGE END against outer mid-thigh (with or without clothing) • PUSH DOWN HARD until a click is heard or felt and hold in place for 3 seconds • REMOVE EpiPen. DO NOT MESSAGE. • CALL 911! • Send used auto-injector with EMS. • Do not refrigerate – Don not expose to extreme cold or heat. • Note the expiration date – Replace when date is approaching.

Medical Information – To be completed by Physician's Office

Allergic to: _____

Current Mediation: _____

_____

Chronic Illnesses/special considerations: _____

_____

Emergency Plan for Exposure to Allergens:

❑ Oral Medication/Inhaler: _____

❑ Epinephrine Injection: _____
(The EpiPen is to be provided by the parents. Staff will be trained by the school RN on the indication & proper technique)

❑ Student to carry EpiPen, inhaler or medication on person.

Physician's Signature: _____ ***Date:*** _____

I, the parent or guardian of the above student, request that this Individual Health Plan (IHP) be administered to my child. I understand that it is my responsibility to provide the school with the necessary supplies and medication and will notify the school if there is any change to my child's health status. I agree to provide a new consent for any changes in doctor's orders and authorize the school nurse. To communicate with the physician when necessary. I understand that this information will be shared with the appropriate members of the educational team.

Parent's/Guardian's Signature: _____ Date: _____

Reviewed by: _____ Date: _____