Individual Health Plan (IHP) *Allergies*

Control environment whenever possible. Reminder: Take this form on Field Trips

Student			DOB			
Grade		Scho	ool Year			
Age of Diag	nosis	Trigg	ger			
1. 2. 3.					Home Phone	
Health Care	e Provider			Phone:		
Hospital/City						
Prevention Strategies: Avoid known triggers for a □ milk/dairy □ nuts □ eggs □ insect bites (kind) □ animals (kind)			□ latex □ seafood			
Symptoms: (Check any past symptoms known) ☐ GI symptoms ☐ generalized tingling or itching ☐ tightness of throat and/or chest ☐ swelling of eyes, lips, tongue, throat or neck ☐ generalized rash or hives ☐ loss of consciousness ☐ apprehension/anxiety ☐ acute coughing or sneezing ☐ facial flush			□ cyanosis-blue lips or finger nails □ rapid, thready, weak, or unattainable pulse □ wheezing or difficulty in breathing □ drop in blood pressure □ fainting □ seizures □ other			
Medication	IS:					
2. 3. 4.	Action: If mild reaction use medication and contact parent- if no improvement go to #2. Drug Name Dose Frequency Give Epipen mg *ONLY Trained staff may give Epipen. Call 911 – Notify office when 911 is called. Call School Nurse at To use Epipen- Pull off gray cap, place on thigh over clothes					
	 Remain calm a Provide CPR b Delegate anoth Other 	needed.	Push in ui Hold in pla	ntil you hear it click ace 10 seconds for 10 seconds		
After Scho	ol Plan					
Bus Plan						

Health Education:	(Circle if applicable) T	=Taught D=Demonstrated mastery				
Date	Date					
T D	triggers					
		egies				
		otoms				
T D						
	_					
	effectivene	effectiveness				
	side effect					
· ——— - ———						
T D review of emergency care plan						
ι υ	D other					
Potential for lack and its treatment	-threatening condition. k of knowledge of anaphylaxis	Goals:1. To maintain cardiac and respiratory function.2. To promote understanding of prevention and treatment.3. Other				
ransportation in		resported by ambulance to the hospital. responsibility of the parent/guardian. Any parent/guardian.				
Please add anythin	g else you would like school p	ersonnel to know about your child's allergy:				
nformation was pro	 ovided by:					
·	Name	Relationship Date				
contact my physicia appropriate school	n regarding this plan. The nu	s the nurse in the building my student attends to rse will also provide a copy of this plan to my child's safety and well being. I will also keep the n or contact information.				
Parent	/Nurse Signature	Date				
Parent	/Nurse Signature	Date				
Parent	/Nurse Signature	Date				
Parent	/Nurse Signature	Date				
Parent	/Nurse Signature	Date				
Parent	/Nurse Signature	Date				