

Please return to Nurses’ Office



1143 Delsea Drive • Westville, NJ 08093 • Phone: 856-812-6030 • Website: adsschool.org

 **N6 Allergy Health Care Plan 2025-2026**

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| --- |
| **Name:**  |
| **Date of Birth:**  | **Date:** |
| **Allergic to:** **Severe Allergy to (REQUIRES EPIPEN):**  |

### »STEP 1: SIGNS & SYMPTOMS OF AN ALLERGIC REACTION

**If Student has these Symptoms:** **Give these Medications:**

 **Antihistamine Epinephrine**

Mouth Itching, tingling, or mild swelling of the lips [ ]  [ ]

Skin Mild hives, itchy rash [ ]  [ ]

Skin Mild hives, itchy rash unresponsive to [ ]  [ ]

 antihistamine after 20 minutes

Skin Severe hives, swelling of face or extremities [ ]  [ ]

Gut Nausea, abdominal cramps, vomiting, diarrhea [ ]  [ ]

Throat Tightening of throat, hoarseness, hacking cough [ ]  [ ]

Lung Shortness of breath, repetitive coughing, [ ]  [ ]

 wheezing

Heart Thready pulse, low blood pressure, fainting, pale [ ]  [ ]

Other [ ]  [ ]

|  |  |  |
| --- | --- | --- |
|  | Antihistamine to give: |  |
|  | (Medication/dose/route) |
|  |  |
|  | Epinephrine to give: |  |
|  | (Medication/dose/route) |

 **»STEP 2: EMERGENCY CALLS**

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| **1**. **Call**  **911.**State that an allergic reaction has occurred and additional epinephrine may be needed |
| **2. Call Parent/Guardian:**   | **Home phone:**  |

**PHYSICIAN SIGNATURE \_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

 **PARENT SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Received\_\_\_\_\_\_\_\_\_\_\_\_ Copies: Nurses\_\_\_\_ CBI\_\_\_\_ Student Binder\_\_\_\_\_\_**