

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**

|  |  |
| --- | --- |
| **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**

|  |  |
| --- | --- |
| **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\_\_\_\_\_\_**