GRIFFIN-SPALDING COUNTY SCHOOLS

SEVERE ALLERGY HEALTH CARE PLAN

SCHOOL YEAR: ____________

ALLERGY TO: ________________________________

ASTHMATIC: ____YES ____NO *HIGH RISK FOR SEVERE REACTION

Student's Name: ______________________________ DOB: __________ Teacher: ______________

School: ____ Grade/Team: ______________

SIGNS OF AN ALLERGIC REACTION INCLUDE:

NOTE: The severity of symptoms can change quickly. ALL symptoms can potentially progress to a life-threatening situation!

MOUTH: itching and swelling of the lips, tongue or mouth

THROAT: itching and /or a sense of tightness in the throat, hoarseness and hacking cough

SKIN: hives, itchy rash, and /or swelling about the face or extremities

GI TRACT: nausea, abdominal cramps, vomiting and/or diarrhea

LUNGS: shortness of breath, repetitive coughing and/or wheezing

HEART: weak and "thread" pulse, "passing out"

ACTION:

1. If ingestion, exposure or sting is suspected, give the following medication immediately.
   Medication: ____________________
   Dosage: ____________________
   Route: ____________________
2. CALL 911 (EMERGENCY MEDICAL SERVICES) IMMEDIATELY!!!!
3. Call Mother ____________________ Father ____________________ or emergency contacts.
4. Call Physician: ____________________________ at ____________________________.

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL EMS EVEN IF PARENTS OR PHYSICIAN CANNOT BE REACHED!

EMERGENCY CONTACTS	TRAINED SCHOOL STAFF
Name: ____________________ Relation: ____________________ Phone: ____________________	Name: ____________________ Room: ____________________
Name: ____________________ Relation: ____________________ Phone: ____________________	Name: ____________________ Room: ____________________

Physicians Signature: ________________________________ Date: ______________________

Physicians Name: ________________________________ Phone Number: ________________

I, (parent/guardian) ________________________, hereby authorize (Healthcare Provider) ________________________, who has attended to my child, ________________________, to furnish to the (School Nurse Supervisor or designee), any medical information and/or copies of records pertaining to my child's severe allergy and for this information to be shared with pertinent school staff. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act (HIPPA) disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Griffin-Spalding County Schools. This authorization expires as of the last day of the school year.

Parent/Guardian Signature: ________________________________ Date: ________________