Office of Student Health Services
Chesterfield County Public Schools

Individualized Healthcare Plan

Healthcare Plan effective for the current school year, including summer school.

Anaphylaxis/ Life-Threatening Allergic Reaction
AAA-1075
(IHP-LTA)
Revised 7/2025

DOB: _____ **Grade:** _____

Student Name: _____ **School:** _____

To be completed by Licensed Healthcare Provider (Physician, Physician's Assistant or Nurse Practitioner):

Allergy to:

ICD 10: _____

Student has asthma ☐ YES ☐ NO
(If YES, higher chance of severe reaction)

Student has had anaphylaxis ☐ YES ☐ NO
If YES, date of last reaction: _____

IMPORTANT REMINDER: ***Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.***

What to look for:

***Any** of the following **severe** symptoms:*

- **Lung:** Shortness of breath, wheezing, repetitive cough
- **Heart:** Pale or bluish skin, faintness, weak pulse, dizziness
- **Throat:** Tight or hoarse throat, trouble breathing or swallowing
- **Mouth:** Significant swelling of the tongue or lips
- **Skin:** Many hives over body, widespread redness, swelling
- **Gut:** Repetitive vomiting, severe diarrhea
- **Other:** Feeling something bad is about to happen, anxiety, confusion

or a combination
of symptoms from different body areas

☐ ***Special Situation:*** ***If this box is checked, student has an extremely severe allergy to an insect sting or the following food(s):***

_____

Even if child has MILD symptoms after a sting or eating these foods, GIVE EPINEPHRINE.

What to do:

Give Epinephrine!

- **INJECT EPINEPHRINE IMMEDIATELY!** Note time when epinephrine was given.
- **CALL 911.** Advise EMS anaphylaxis suspected and epinephrine has been given.
- Keep student lying down.
- Notify parent if not already contacted.
- Remain with student and observe for difficulty breathing until EMS personnel arrive.
- Give a second dose of epinephrine 5 minutes or more after first injection if symptoms get worse, do not improve, or return.
- Give other medication, if prescribed (e.g.antihistamine/bronchodilator). Do not use other medication in place of epinephrine.
- Start CPR if breathing or heart stops.

Follow up care with a health care provider is necessary. The student will not be allowed to remain at school or return to school on the day epinephrine is administered.

What to look for:

***Mild** symptoms from a single system area:*

- **Nose:** Itchy or runny nose, sneezing
- **Mouth:** Itchy mouth
- **Skin:** A few hives, mild itch
- **Gut:** Repetitive vomiting, severe diarrhea
- **Gut:** Mild nausea or discomfort

What to do:

Monitor Student

- Give antihistamine (if prescribed)
- Watch student closely
- Contact parents
- **Gut:** Repetitive vomiting, severe diarrhea
- If symptoms worsen, ***or more than one mild symptom develops***, **GIVE EPINEPHRINE** and follow the directions in the above box

DOB: _____ **Grade:** _____

Student Name: _____ **School:** _____

To be completed by Licensed Healthcare Provider (Physician, Physician's Assistant or Nurse Practitioner):

Medications/Doses

Epinephrine, intramuscular (list type): _____ **Dosage (check one):** ☐ **0.15mg** ☐ **0.3mg**

Student is capable of carrying their own epinephrine auto injector ☐ YES ☐ NO

Student has been instructed and is capable of self-administering their own epinephrine auto injector ☐ YES ☐ NO

Antihistamine, by mouth (type and dose): _____

Other (e.g. inhaler-bronchodilator) type and dose: _____

Additional Instructions: _____

_____

_____

Licensed Healthcare Provider

_____ _____

Licensed Healthcare Provider Name (Print) / Signature **NPI#** **Phone Number** **Date**

To be Reviewed and Signed by PARENT/GUARDIAN:

☐ **I have reviewed and agree to this health plan for my student and understand that school staff /school nurse may communicate with my child's Licensed Healthcare Provider (LHP) regarding this health plan. I acknowledge that I am responsible for providing the school with all medications and supplies required to implement the plan as ordered by the LHP.**

_____ _____ _____ _____

Parent/Guardian Name (Print) **Parent/Guardian (Signature)** **Date** **Phone Number**

_____ _____ _____

School Nurse Name/Signature **Date Received** **Date Emergency Action Plan Distributed**