



# Waterford School District – Plan of Care (POC) - Allergy/Asthma Management

Bus Route #: \_\_\_\_\_

Student Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

The student's asthma and \_\_\_\_\_ allergy can be life threatening. Signs of an allergic reaction and asthma episode may include the following: (items checked are ones usually experienced by the student)

<p>Signs of an <u>allergic</u> reaction include:</p> <p><b>*Mouth:</b> <input type="checkbox"/> Itching and Swelling of the Lips <input type="checkbox"/> Tongue  <input type="checkbox"/> Mouth</p> <p><b>*Throat:</b> <input type="checkbox"/> Itching <input type="checkbox"/> Sense of Tightness in the Throat  <input type="checkbox"/> Hacking Cough</p> <p><b>Skin:</b> <input type="checkbox"/> Hives <input type="checkbox"/> Itchy Rash <input type="checkbox"/> Swelling about the Face or Extremities</p> <p><b>Gut:</b> <input type="checkbox"/> Nausea <input type="checkbox"/> Abdominal Cramps <input type="checkbox"/> Vomiting  <input type="checkbox"/> Diarrhea</p> <p><b>*Lung:</b> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Repetitive Coughing  <input type="checkbox"/> Wheezing</p> <p><b>*Heart:</b> <input type="checkbox"/> Thready Pulse <input type="checkbox"/> Fainting</p>	<p>Signs of an <u>asthma</u> episode include:</p> <p><input type="checkbox"/> Coughing  <input type="checkbox"/> Wheezing  <input type="checkbox"/> *Difficulty Breathing, Walking, Talking  <input type="checkbox"/> *Blue or Grey Discoloration of Lips or Fingernails  <input type="checkbox"/> *Increased Anxiety  <input type="checkbox"/> Other</p> <p>If the student experiences the above symptoms</p> <ol style="list-style-type: none"> <li>1. Calm student</li> <li>2. Encourage slow, deep breathing exercises</li> <li>3. Give medication _____        (Doctor, please indicate type of medication above)</li> <li>4. Stay with student fifteen (15) minutes.</li> <li>5. Send back to class if improved status.</li> <li>6. Contact Parents.</li> </ol>
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***\*The severity of the above symptoms can quickly change. Above symptoms can potentially progress to a life-threatening status.***

**If the student suspects that an allergic reaction is happening or if the student experiences any feeling of the throat closing:**

**Treat as a MAJOR Reaction:**

- **Inject one Epi-Pen immediately into the student's upper outer thigh**
- **Call 911**
- **Monitor closely until help arrives**

**Call Parents:** Home Phone: \_\_\_\_\_

Mother: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

In the event that special accommodations are required, the school district may need up to five (5) school days to comply with the request. It will be up to the parent and the physician to determine if the child shall attend school during that time.

\_\_\_\_\_  
PARENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

Physician Name \_\_\_\_\_

Physician Address \_\_\_\_\_

Physician Phone \_\_\_\_\_