LATEX ALLERGY CARE PLAN – LATEX ALLERGY

CONFIDENTIAL

Student's Name_____________________________Grade________School________________ year_______

Parent/Guardian: _____________________________Phone # Work: ____________Home #________________

Physician: __________________________________Phone #____

Family member/Friend-aware of child's condition-Name: _______________________Phone#______________

Symptoms of my child's allergic reaction:____

Date of last allergic reaction: ________________________

Does your child require medication at school if he/she comes in contact with latex? ❑ Yes ❑ No

Please tell us what you want us to do in case of an allergic reaction at school.

(Please check all that apply)

☐ Wash contact area with soap and water

Symptoms:	**Give Checked Medication:**
If contact with latex, but NO symptoms:	use ☐ Epinephrine ☐ Antihistamine
Mouth: itching, tingling or swelling of lips, tongue, mouth:	use ☐ Epinephrine ☐ Antihistamine
Skin: hives, itchy rash, swelling of the face or extremities:	use ☐ Epinephrine ☐ Antihistamine
Gut: nausea, abdominal cramps, vomiting, diarrhea:	use ☐ Epinephrine ☐ Antihistamine
***Throat:** Tightening of throat, hoarseness, hacking cough:	use ☐ Epinephrine ☐ Antihistamine
***Lung:** Shortness of breath, repetitive coughing, wheezing:	use ☐ Epinephrine ☐ Antihistamine
***Heart**: Fainting, pale, blueness, weak or thready pulse, low blood pressure:	use ☐ Epinephrine ☐ Antihistamine
***other**: ____	use ☐ Epinephrine ☐ Antihistamine
If reaction is progressing (several of the above areas affected)	use ☐ Epinephrine ☐ Antihistamine

***Potentially life-threatening. The severity of symptoms can quickly change.**

Dose of Epinephrine: ☐ 0.15mg IM ☐ 0.3mg IM **Dose of Antihistamine:** ___________________________

Other (e.g., inhaler-bronchodilator if asthmatic:)____

☐ Notify parent by: ❑ Send note home ❑ Call parent by phone

☐ Allow to rest for _______________ minutes.

☐ Call 911 if: ____

☐ Other/Comments: ____

(If medication is needed at school, and/or field trips/extracurricular activities, you must have a supply of the medication and the permission form signed by the parent and your child's doctor on file for this school year.)

Parent Signature____Date___________________________

School Nurse Signature _____________________________________Date of review___________________

Physician Signature ____Date ___________________________

Upon completing this form, please print the form and hand it in at registration OR save it and email the form to Susan Resch, RN, BSN at sresch@newlondon.k12.wi.us. If medication is needed for this concern, you must also fill out a medication consent form.

Thank you.