**Allergies and Sensitivities Healthcare Plan**

| **Name:** | | FirstName LastName | | **Date of Birth:** | | | Enter DOB Here |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **These are my medical diagnoses:** | | List all diagnoses. | | | | | |
| **I am allergic or sensitive to these things:** | | List all known allergies and sensitivities | | | | | |
| **The goal of this Healthcare Plan is:** | | I will not experience any illness related to allergies and sensitivities for the duration of the ISP year.  I will be free of severe allergic reaction/anaphylaxis for the duration of the ISP year.  I will be as active as possible in spite of my allergies and sensitivities.  Describe any other goal related to my routine and preventative services. | | | | | |
| **Progress in the past year:** | | Describe the status of my preventative and routine services in the past year, including whether any recommended procedures were not completed. | | | | | |
| **In an EMERGENCY**  **Call 911 IMMEDIATELY if I:**  **🡪 lose consciousness (become unresponsive);**  **🡪 show any of these signs of anaphylaxis (severe allergic reaction):**   * **shortness of breath;** * **swelling of throat, lips, and/or tongue;** * **trouble breathing;** * **vomiting; or** * **weak pulse.**   **🡪 Describe any additional instructions specific to allergies and sensitivities here.** | | | | | | | |
| **DO NOTMAKE NOTIFICATIONS PHONE CALLS UNTIL**  **I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** | | | | | | | |
| **I have NEVER had anaphylaxis (severe allergic reaction)** | **I have had anaphylaxis (severe allergic reaction) within the PAST YEAR.** | | **I have had anaphylaxis (severe allergic reaction) within the past THREE YEARS.** | | | **I have had anaphylaxis (severe allergic reaction) one or more times in my LIFETIME.** | |
| **These are foods I should avoid because I have had a reaction in the past when eating/drinking:** | List food or beverage allergens, or indicate if there are NONE. | | **These are things in my environment I should avoid because I have had a reaction in the past when exposed:** | | List environmental allergens, or type NONE. Include allergies to pets, insect stings, latex allergies, dust, pollen, grass, mold, etc. in this section. | | |
| **These are the sedation(s) that I must avoid based on past experience.** | List environmental allergens, or type NONE. Include allergies to pets, insect stings, latex allergies, dust, pollen, grass, mold, etc. in this section. | | **These are medications I should avoid, because I have had a reaction in the past.** | | List medication allergies or sensitivities, or indicate if there are NONE. | | |
| **These are the sedation(s) that I must avoid based on past experience.** | | List sedation(s) which have caused a reaction for me in the past. (List the reaction and year) or indicate if there are none. | | | | | |
| **These are the changes in my body that occur when I have an allergic reaction or sensitivity.** | | Runny nose and sneezing  Itchy, red, watery eyes  Headache  Lethargy (feeling more tired than usual)  Hives (swollen red areas that appear suddenly on my skin after I’ve been exposed to an allergen)  Skin rash  Wheezing  Coughing  Stomach pain/cramps  Vomiting  Diarrhea  Increased seizure activity  **Other:** Describe other allergic reactions or sensitivities or indicate if there are none. | | | | | |
| **I rely on supporters to help me take these steps to avoid health problems related to allergies and sensitivities.** | | Take my regular and PRN allergy medications as prescribed.  Avoid these foods and beverages that contain these things: LIST  Assist me in washing all clothes and bedding using hypoallergenic and perfume-free detergents.  Assist me in using hypoallergenic shampoos, soaps, and lotions that have been recommended or approved by my doctor.  Support me in avoiding things in my environment that cause allergies in me, such as pets and stinging insects.  Make sure that I have an Epi-Pen with me at all times.  **Other**: Describe any other instructions for supporters to follow to help reduce my allergies/sensitivities, or indicate if there are none. | | | | | |
| **In case of exposure to allergens known to cause anaphylaxis (severe allergic reaction), help me do these things:** | | Use Epi-Pen per package instructions.  Administer PRN allergy medications as ordered.  Call 9-1-1 if I experience a severe reaction (see box above).  Notify my nurse as soon as I am stable and follow instructions.  **Fluid Intake**: Measure and record my fluid intake on the enter name of form each time I consume any fluids.  **Meal Intake**: Record amounts of solid foods I consume on the enter name of form each time I eat. Refer to Intake/Output healthcare plan for details.  **Output**: Record my urine output on the enter name of form each time I void.  **Seizures**: Record all of my seizures on the seizure log.  **Oral Hygeine**: Record each time I perform oral hygiene.  **Skin**: Observe skin during care and record and report any concerns.  **Other:** Describe any other instructions for supporters to follow in case of anaphylaxis, or indicate if there are none. | | | | | |
| **Documentation:** | | Describe the things that supporters should write down and where they should write them down. | | | | | |
| **Nursing Intervention:** | | Describe those things that must be done by the nurse relative to allergies and sensitivities, including those non-delegable duties listed in O.C.G.A. § 43-26-32 or HRST Q Score. | | | | | |

**Signature of RN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RN Typed Name and Agency

This healthcare plan is reviewed at least annually and promptly revised as my diagnosis/risk status changes.

**Review date: \_\_\_\_\_\_\_\_ Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan revision required?** Yes No

RN Typed Name and Agency

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