**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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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

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