ALLERGY EMERGENCY PLAN

Student Name: _____ **Student ID:** _____ **DOB:** _____ **School Name:** _____ **School Year:** _____
Parent Name: _____ **Home:** _____ **Work:** _____ **Cell:** _____

Allergic to:_____**Describe Symptoms:**_____

Asthmatic: ☐ ***Yes** (Children with asthma have a higher risk for severe reaction) ☐ **No**

DO NOT DEPEND ON ASTHMA INHALER AND/OR ANTIHISTAMINES TO TREAT ANAPHYLAXIS!!!

Antihistamines and Epinephrine Auto-Injectors need to be provided to school by parents with required documentation.

Minor Symptoms	**Skin**	• **Localized rash or hives or redness**
	GI	• **Nausea or single episode of vomiting** • **Abdominal pain**

GIVE

Med: _____Dose:_____ by mouth

(Name of Antihistamine, i.e. Benadryl, and dose)

WATCH CLOSELY FOR WORSENING SYMPTOMS

OR

Major Symptoms	**Skin**	• **Red, itchy rash around mouth or on face** • **Itching of face with or without swelling** • **Scattered hives over the body** • **Eczema "flare-up"**
	Respiratory	• **Hoarseness** • **Stridor (Abnormal high pitched sound when breathing in)** • **Difficulty breathing/shortness of breath** • **Repeated coughing/wheezing** • **Chest tightness**
	GI	• **Repeated vomiting** • **Drooling or difficulty swallowing**
	Cardio-vascular	• **Weak, rapid pulse** • **Lightheadedness or feeling faint** • **Loss of consciousness**

GIVE

****GIVE EPINEPHRINE NOW****

Name of Injector: _____ Dose: _____

AND IF POSSIBLE GIVE

Med: _____Dose:_____ by mouth

(Name of Antihistamine, i.e. Benadryl, and dose)

*****CALL 911*****

OPTION 1 OR 2 NEEDS TO BE COMPLETED AND SIGNED BY A PHYSICIAN IF STUDENT IS TO CARRY AND/OR SELF-ADMINISTER EPINEPHRINE:

☐ **1.** I have instructed student in the proper use and dosage of his/her epinephrine auto-injector. It is my professional opinion that this student should be allowed to carry and self administer _____ (medication name and dose).

☐ 2. This student should be allowed to carry this epinephrine auto-injector while at school and on school bus. Student is not capable of administration of this medication _____ (medication name and dose).

Physician's Signature: _____ Date: _____

_____ _____

Parent Signature Date County School Nurse Signature Date

Revised 4/16