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

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