Allergy Emergency Action Plan

Student's Name:_____ **Student #:** _____ **D.O.B:**_____

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

Parent/Guardian: (Home) (Work) (Cell)

Mother:

Father:

Other emergency Contact: _____ Phone: _____

If These Symptoms: Then Give Checked Medication**:

**(To be determined by physician authorizing treatment)

- If allergen has been ingested (food, sting), but *no symptoms*: ☐ Epinephrine ☐ Antihistamine
- Mouth: Itching, tingling, or swelling of lips, tongue, mouth ☐ Epinephrine ☐ Antihistamine
- Skin: Hives, itchy rash, swelling of the face or extremities ☐ Epinephrine ☐ Antihistamine
- GI: Nausea, abdominal cramps, vomiting, diarrhea ☐ Epinephrine ☐ Antihistamine
- Tightening of throat, hoarseness, hacking cough ☐ Epinephrine ☐ Antihistamine
- Shortness of breath, repetitive coughing, wheezing ☐ Epinephrine ☐ Antihistamine
- Thready pulse, low blood pressure, fainting, pale, blueness ☐ Epinephrine ☐ Antihistamine
- Other _____ ☐ Epinephrine ☐ Antihistamine
- If reaction is progressing (several above areas affected), give: ☐ Epinephrine ☐ Antihistamine

If epinephrine is administered during a reaction, call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed. Send used epinephrine injection device with student to Emergency Room.

Antihistamine: give: _____
medication/dose/route/frequency

Epinephrine: inject intramuscularly (circle all that apply) EpiPen® EpiPen® Jr . Twinject™ 0.3 mg Twinject™ 0.15 mg **Please note**: Columbia Public Schools have EpiPen® on site.

Other: give: _____
medication/dose/route/frequency

Doctor's Signature_____ Date_____
(Required)

Parent Consent for Management of Allergic Reaction at School

I, the parent or guardian of the above named student, request this emergency action plan be used to guide allergy care for my child. I agree to:

1. Provide necessary supplies and equipment, including EpiPen® and benadryl if prescribed.
2. Notify the school nurse of any changes in the student's health status.
3. Notify the school nurse and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school nurse to communicate with _____, the primary care provider/specialist about allergy as needed.
5. Allow school staff interacting directly with my child to be informed about his/her special needs while at school.

Parent/Guardian Signature_____ Date_____