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_______________