COMMITTED TO STUDENT SUCCESS

HEALTH OFFICE PROCEDURE

ALLERGY ACTION PLAN

Form to be completed by Parents/Guardians and Child's Health Care Provider.

Student's Name _____ Date of Birth _____

Grade _____ Homeroom Teacher _____

ALLERGY TO: _____

Asthma	☐ Yes ☐ No	If yes, higher risk for a severe reaction
SIGNS OF AN ALLERGIC REACTION MAY INCLUDE:		
Mouth	Itching and swelling of the lips and/or tongue	
Throat	Itching, tightness, hoarse, hacking cough, trouble breathing/swallowing	
Skin	Hives, itchy rash, and/or swelling about the face or extremities	
Gut	Nausea, crampy pain, vomiting and/or diarrhea	
Lungs	Short of breath, wheeze, repetitive cough	
Heart	Pale, blue, faint, weak pulse, dizzy, confused	
Any of these symptoms may progress to a life-threatening situation.		

ACTION FOR MINOR REACTION

If only symptom(s) are: _____

Administer: Medication _____ Dose: _____ Route _____

Call parent/guardian immediately.

ACTION FOR MAJOR REACTION

If condition does not improve within _____ **minutes and ingestion is suspected and/or symptom(s) are:** _____

Administer: Medication _____ Dose: _____ Route _____

Call parent/guardian immediately.

Call: **911 stating "pediatric severe allergic reaction"**

Medications/Doses – to be provided to the school

Epinephrine (brand and dose): _____

Antihistamine (brand and dose) _____

Other (e.g., inhaler-bronchodilator if asthmatic):

Monitoring

Stay with student; alert healthcare professionals and parent. Tell EMS that epinephrine was given. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised.

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Contact Information

Mother/Guardian _____

Telephone: Home _____ Work _____ Cell _____

Father/Guardian _____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:

Name _____

Address _____

Telephone _____ Emergency Number _____

Other Emergency Contacts:

Name _____ Relationship _____

Telephone: Home _____ Work _____ Cell _____

Name _____ Relationship _____

Telephone: Home _____ Work _____ Cell _____

Please remember to let your child's school know of any changes to the contact information as soon as possible.

Signatures

This Allergy Information Form has been reviewed and approved by:

_____ _____

Student's Physician/Health Care Provider Date

_____ _____

Student's Parent/Guardian Date

PERMISSION TO CARRY EPI - PEN: (if YES, Please complete the following) ☐ **Yes** ☐ **No**

We request that (Student's Name) _____ be permitted to carry his/her EPI - pen on his/her person or on off campus related activities or to keep it in his/her classroom, backpack. He/she has been instructed in and understands the purpose and appropriate method of use of his/her EPI - pen and understands the importance of reporting immediately to the school health aide after using the EPI-pen. We understand that a **911 call** is required after the use of the EPI - pen. We the undersigned physician and parent /guardian, release the school district and its employees, agents and officers of any responsibility in safeguarding this child's EPI- pen.

_____ _____

Student's Physician/Health Care Provider Date

_____ _____

Student's Parent/Guardian Date