CARROLLTON-FARMERS BRANCH ISD
cfb HIGH EXPECTATIONS FOR ALL

EMERGENCY ACTION PLAN FOR ALLERGY/ANAPHYLAXIS

Student Name: ________________________________ Date of Birth: ________________Grade/Teacher: ________________

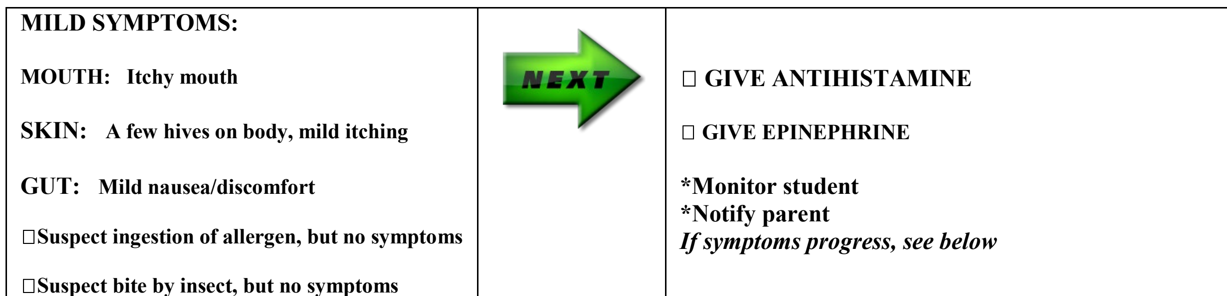
STUDENT'S KNOWN ALLERGIES: ____

Asthmatic: ☐ NO ☐ **YES *higher risk for severe reaction**

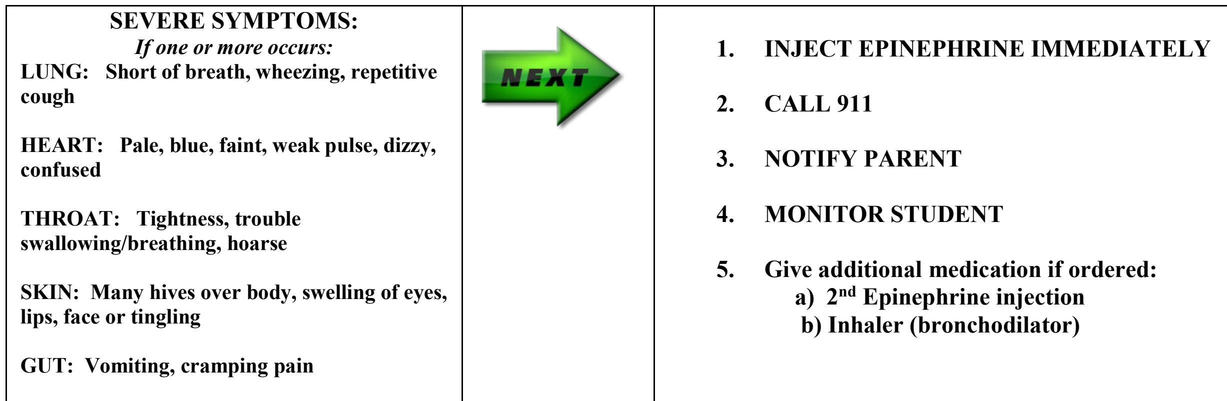
Physician's name: _____________________________Phone number: ________________Fax number: __________________

PARENT/GUARDIAN/EMERGENCY CONTACTS:

Name	Home Number	Work Number	Mobile Number
1.			
2.			
3.			



MILD SYMPTOMS:		
MOUTH: Itchy mouth **SKIN: A few hives on body, mild itching** **GUT: Mild nausea/discomfort** ☐**Suspect ingestion of allergen, but no symptoms** ☐**Suspect bite by insect, but no symptoms**	NEXT	☐ **GIVE ANTIHISTAMINE** ☐ **GIVE EPINEPHRINE** ***Monitor student** ***Notify parent** ***If symptoms progress, see below***



SEVERE SYMPTOMS: *If one or more occurs:*		
LUNG: Short of breath, wheezing, repetitive cough **HEART: Pale, blue, faint, weak pulse, dizzy, confused** **THROAT: Tightness, trouble swallowing/breathing, hoarse** **SKIN: Many hives over body, swelling of eyes, lips, face or tingling** **GUT: Vomiting, cramping pain**	NEXT	**1. INJECT EPINEPHRINE IMMEDIATELY** **2. CALL 911** **3. NOTIFY PARENT** **4. MONITOR STUDENT** **5. Give additional medication if ordered:** **a) 2nd Epinephrine injection** **b) Inhaler (bronchodilator)**

MEDICATIONS/DOSAGES

Epinephrine (name/dosage) ____
2nd Epinephrine (name/dosage and time if indicated) ____
Antihistamines (name and dosage) ____
Other (inhaler, bronchodilator, etc.) ____

Middle/high school only:

☐ I authorize that this student may carry and self-administer the above medication at school and school related events.

☐ This student is **NOT** authorized to carry or self-administer the above medications at school or school related events.

Physician's signature ____________________________________Date ___________________________

YES, NO **I** give permission for a trained school employee to administer the above medications to my child if an RN is not present. If NO, 911 will be called.

YES, NO I give permission to my child to carry an epi-pen at school and school related events and to self medicate.

YES, NO I give permission for my child to self medicate in the presence of a school nurse or trained school employee.

Parent/Guardian Signature____Date____________