Revised 4/11/19

Cleburne ISD Health Services
SEVERE ALLERGY ACTION PLAN

Name: _____D.O.B._____ School Year: _____

HISTORY OF ALLERGY REACTION (*To be completed by parent/guardian*)

Allergic to: _____ Age discovered _____
Allergy Reaction was caused when substance was: **___Ingested (eaten) ___Contacted (touched) ___Inhaled**
Describe what happened (list symptoms): _____
_____
Was an emergency injection used for the allergy reaction? _____ If so, when? _____
Was student treated in an ER or hospitalized for an allergy reaction? _____ If so, when? _____
Do you take any special precautions to reduce student's risk of an allergy reaction? _____
_____
Does student have a history of Asthma? **___ No___ *Yes ___ (*Higher risk for severe reaction)**
To request a special diet or modification of a meal plan at school, please contact your campus nurse.

EMERGENCY CONTACTS

1. Physician/PA/NP: _____ Phone: _____Fax: _____
2. Parent/Guardian: _____ Phone: _____
3. Non-custodial Emergency contact: _____ Phone: _____
   Relation: _____ Secondary #: _____

Teacher/Staff Management of Anaphylaxis Symptoms

MOUTH Itching and swelling of the lips, tongue, or mouth
SKIN Hives, itchy rash, and/or swelling of the face or extremities
GUT Nausea, abdominal cramps, vomiting, and/or diarrhea
THROAT * Itching and /or a sense of tightness in the throat, hoarseness, and hacking cough
LUNG * Shortness of breath, repetitive coughing, and/or wheezing
HEART * Thready, weak pulse, passing out

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All above symptoms can potentially progress to a life-threatening situation.

Place Student's Photo Here

EMERGENCY ACTION PLAN AND MEDICATION AUTHORIZATION
(To be written as prescription order and completed by physician, PA, NP)

- Give EPINEPHRINE intramuscularly *(Physician, circle one)*
  EpiPen 0.3mg **EpiPen Jr. 0.15mg** **Twinject 0.3mg** **Twinject 0.15mg** **Auvi-Q 0.3mg**
- For mild allergy reactions (skin rash only) or in addition to Epinephrine injection give;
  Antihistamine: _____Dose: _____Route: _____
- **CALL 911/RESCUE SQUAD**. Notify EMS that a severe allergic reaction has been treated and additional Epinephrine may be needed.
  Permission is granted for designated school personnel to administer above medication to student as prescribed by student's physician

Self-Carry Emergency Injection Administration (*To be completed by physician, PA, NP*)

I have trained and instructed _____ in the proper way to use his/her emergency medication, (Epinephrine injection).

____ YES ____NO This student meets the criteria to carry and self-administer his/her emergency medication.

Physician, PA, NP signature: _____ Date: _____

***Parent/Guardian signature: _____ Date: _____**

*My signature indicates that I am giving permission for CISD staff to contact the physician for additional information, if needed.