

Dudley-Charlton Regional School District
Emergency Health Care Plan
Allergy Action Response

Name: _____ Grade: _____

What Allergy Does the Child Have: _____

Is This Child at High Risk for Severe Reaction? Yes _____ No _____
Has This Child Ever Used an Epi-pen for Reaction: Yes _____ No _____
Has This Child Ever Been Hospitalized for Allergy: Yes _____ No _____
Is This Child Asthmatic: Yes _____ No _____

Please Indicate Symptoms Child Develops:

- ___ 1. Itching and swelling of the lips, tongue or mouth
- ___ 2. Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
- ___ 3. Hives, itchy rash and/or swelling about the face or extremities
- ___ 4. Nausea, abdominal cramps, vomiting and/or diarrhea
- ___ 5. Shortness of breath, repetitive coughing and/or wheezing
- ___ 6. "Thready" pulse, "passing out"

ALL ABOVE SYMPTOMS CAN POTENTIALLY PROGRESS TO A LIFE-THREATENING SITUATION.

ACTION PLAN

1. If child has been exposed to an allergen or ingestion is suspected with symptoms of: _____
Give: _____ Immediately!
2. Medication to be kept at school (in order to be given):
 1. _____
 2. _____
3. Call 911, notify EMS of allergic reaction and Epi-pen Administration.
4. Call Parent/Guardian: _____ at: _____
5. *Child must carry Epi-pen in fanny pack:* ___ Bus only ___ At all times ___ Not needed
6. Child should be seated in front seat of bus. Yes _____ No _____

We must have a physician's signature if the child has medication to be given for allergic reaction at school.

Physician's Signature: _____ Date: _____

Parent's Signature: _____