Allergic Reaction Plan

Student's Name: _____ Grade: _____

ALLERGY TO: _____ Asthma *Yes _____ No_____ *High risk for severe reaction

Please circle the symptoms your child experiences when having an allergic reaction:

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

***These symptoms can progress to a life-threatening situation**

Date of last reaction: _____

SEVERE ALLERGIC REACTION

1. If allergen contact is suspected, IMMEDIATELY use EpiPen _____mg;
   Give Benadryl _____mg; Other _____
2. Call 911 if condition is unstable. Hospital Preference _____
3. Call: Mother at # _____ Father at #_____ or
   Emergency contacts: _____
4. **Do not hesitate to administer medication or call 911 if anaphylaxis is suspected**

MINOR ALLERGIC REACTION-Please indicate symptoms of minor reaction and action to take:

Self-Administration of EpiPen: Physician and Parent Permission to Carry Medication

Students who are trained to self-medicate for allergic reactions may carry an EpiPen if this form is completed and signed by his/her physician and parent, and on file in the health room.

I have instructed _____ in the proper use of an EpiPen. It is my professional opinion that he/she is responsible to carry and administer this medication.

*Yes_____ No_____

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*If medication is carried by the student, the school district is not responsible for the effects of medication or for ensuring that it is taken. The school nurse must be notified with each use. It is the student's responsibility to have it on field trips. School stocked EpiPens are not sent on field trips.

I give permission to the school district to share information about my child's allergy to help improve the health and safety of my child. I am allowing the school nurse to communicate with the student's MD regarding this treatment. I will notify the school nurse of any changes in this plan.

Parent Signature _____ Date _____

Physician Signature _____ Date _____

(If no medication is needed, an MD signature is not required.)

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