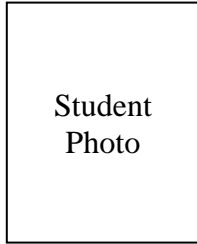


# SHELDON INDEPENDENT SCHOOL DISTRICT ALLERGY ACTION PLAN



Student's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 School \_\_\_\_\_ School Year \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_

**Parents/Guardians Information:**

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Phone # \_\_\_\_\_  
 Name \_\_\_\_\_ Phone # \_\_\_\_\_ Phone # \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_  
 Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_  
 How does the student get home?     Bus     Car Rider     Walker

*I hereby authorize the school, through the nurse or principal designee, to give my child the necessary treatment in case of an allergic reaction as outlined below by the physician and to share information with other school staff members and health care providers on a need-to-know basis. I release Sheldon Independent School District, and any school district employee from any and all liability that may arise related to the treatment and/or care of my child as listed below.*

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS PART NEEDS TO BE COMPLETED BY PRESCRIBING PHYSICIAN**

**ALLERGY TO:** \_\_\_\_\_ **Asthmatic:**  Yes\*     No    *\*Increased risk for severe reaction*

**Triggered by:**  Ingestion     Inhalation     Contact     Other: \_\_\_\_\_ **Is it Life-Threatening:**  Yes     No

**Symptoms of Reaction** \_\_\_\_\_

**Date of Last Reaction** \_\_\_\_\_ **Other allergies:** \_\_\_\_\_

If you suspect or know that student has been exposed to allergen, immediately determine the symptoms and treat the reaction as follows:			
<b>Symptoms:</b>	<b>Give Medication checked "X"</b> <small>(To be determined by authorizing physician)</small>		
<b>If exposed to allergen, but has <i>no</i> symptoms:</b>	<input type="checkbox"/> Monitor	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
For <b>mild symptoms</b> such as itching to mouth or body, hives, <u>localized</u> swelling, swelling to areas around face or extremities, or mild nausea/ discomfort	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	
Mouth:**    Obstructive swelling of tongue and/or lips	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	
Throat:**    Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	
Lung:**    Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	
Heart:**    Thready pulse, passing out, fainting, pale, blueness	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	
Skin:    Hives, swelling on face or extremities, itchy rash	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	
Gut:    Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	
General:    Panic, sudden fatigue, chills, fear of impending doom	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	
<b>If a reaction is progressing (several of the above areas affected):</b>	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	

\*\*Potentially life-threatening.                      The severity of symptoms can quickly change.

**MEDICATION DOSAGE:**

**Epinephrine:** inject intramuscularly once into upper outer thigh and hold for 10 seconds.  
(Check what applies)     EpiPen® 0.3 mg     EpiPen® Jr. 0.15mg     Twinject® 0.3mg     Twinject® 0.15mg  
 Repeat dose of Epinephrine injection if the child's symptoms persist or get worse **within** \_\_\_\_\_ **minutes**

**Antihistamine:** Give \_\_\_\_\_ Dose: \_\_\_\_\_ mg ( \_\_\_\_\_ cc/tsp) by mouth Frequency: \_\_\_\_\_

**Other Medication:** \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Time Given: \_\_\_\_\_

**Special instructions while student is at school:** \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\*\*\*\*DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 EVEN IF PARENTS CANNOT BE REACHED\*\*\*\*\***

**Give medication as ordered. Note the time medication was given.**  
**Call 911. (911 MUST BE CALLED WHENEVER EPINEPHRINE IS ADMINISTERED.)**  
 ----Notify 911 that the child had a severe allergic reaction and has been given epinephrine and more doses may be needed.  
 An adult trained in CPR is to stay with the student to monitor and begin CPR if necessary.  
 Have someone alert the school nurse, parent, and an administrator.  
**If ordered by the prescribing physician, give second dose of epinephrine if symptoms persist or worsen.**