SHELDON INDEPENDENT SCHOOL DISTRICT
ALLERGY ACTION PLAN

Student Photo

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:

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