

# Emergency Action Plan for Allergic Reactions

School Year: \_\_\_\_\_

ALLERGIES (medication, environmental and/or food): \_\_\_\_\_

Student Name:	Grade:
Parent(s)/Guardian:	
Address:	
Phone # (please specify)	

Accidental ingestion or exposure to the above allergen(s) could lead to a severe allergic reaction or anaphylaxis. Signs of an allergic reaction include:

- Mouth – itching and/or swelling of lips, tongue or mouth
- Throat – itching and/or a sense of tightness in the throat, hoarseness or cough
- Skin – hives, itching and/or swelling of the face or extremities
- Stomach – nausea, abdominal cramps, vomiting and/or diarrhea
- Lungs – shortness of breath, repetitive cough and/or wheezing
- Heart – lightheadedness, fainting

**MUST BE COMPLETED BY PRESCRIBING PROVIDER**

## Treatment Plan:

- 1) If an accidental exposure is suspected or mild symptoms of reaction develop, give **Benadryl (diphenhydramine)** \_\_\_\_\_ mg by mouth immediately (\_\_\_\_\_ teaspoons).
- 2) If hoarseness, a sensation of tightness in the throat, difficulty breathing, or any symptoms from two or more of the above symptoms develop, give (  ) **Epinephrine 0.3 mg**, (  ) **Epinephrine 0.15 mg**, and call **911** to arrange transport to the nearest medical facility. **Brand of Epinephrine** \_\_\_\_\_
- 3) Other treatment:

Signature of Provider: \_\_\_\_\_ Date: \_\_\_\_\_

I request and give my permission for school personnel to administer the above medication to my child. I understand it is my responsibility to refill medication when notified, and that any changes in dosage or new medications require a new provider's signature. Discontinuations require a note from a parent. I understand the school is not liable for any adverse reactions.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed/Date \_\_\_\_\_