



ALLERGY Emergency Action Plan

Keller ISD Health Services Department

NAME: _____ DOB: _____ Teacher/Grade: _____

Emergency Contact #1: _____	Preferred Contact # _____
Emergency Contact #2: _____	Preferred Contact # _____
Physician Treating Allergy: _____	Preferred Contact # _____
Preferred Hospital: _____	

Diagnosis/Condition: **ALLERGY** Extremely reactive to following: _____

Is the allergy life threatening? YES/ NO Will Epinephrine be provided? YES/ NO

Date of last reaction? _____ *If yes, parent must provide Epi-Pen/Epinephrine RX

Symptoms exhibited _____ Does student have Asthma? YES/ NO

Triggers? _____

MEDICATIONS FOR ALLERGY TO BE ADMINSTERED AT SCHOOL: (Medication Authorization Form required)

Medication	Dosage	Route
Epinephrine:		
Antihistamine:		
Other:		

This section is to be completed by Physician ONLY

Extremely reactive to the following: _____

If checked, give epinephrine immediately for ANY symptoms if known or suspected contact with allergen.

If checked, give epinephrine immediately if *definite* contact with allergen, even if no symptoms present.

Any SEVERE SYMPTOMS after suspected or known contact:

One or more of the following:

Lungs: Shortness of breath, wheeze, repetitive cough

Heart: Pale, blue, faint, weak pulse, dizzy, confused

Throat: Tight, hoarse, trouble breathing/swallowing

Mouth: Obstructive swelling (tongue or lips)

Skin: Many hives over body, redness/warmth

Or combination of symptoms from different body areas:

Skin: Hives, itchy rashes, swelling (eyes, lips)

Gut: Vomiting, diarrhea, crampy pain

Mild symptoms only:

Mouth: itchy mouth

Skin: a few hives around mouth/face, mild itch

Gut: mild nausea/vomiting



1. Immediately give Epinephrine
2. Call 911
3. Monitor student
4. Give additional medications*

*A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.



1. Give antihistamine
2. Stay with student, call parents
3. If symptoms worsen, give Epinephrine
4. Monitor student

Physician Signature: _____ Date: _____

Student's Name: _____ DOB: _____

DIAGNOSIS/CONDITION: **ALLERGY**
Additional Information

ALLERGEN: _____

--

EPI-PEN/EPINEPHRINE INFORMATION: (always call **911** if Epinephrine administered)

Epinephrine location	
Trained staff/location	
Trained staff/location	
Buddy Nurse/location	
Other:	

For all devices attach the Epi Trainer user guide (located on the Health Services website).

Acknowledged and Received by:

Parent Signature: _____ Date: _____

RN Signature: _____ Date: _____

LVN Signature: _____ Date: _____

Allergy EAP electronically sent via Laserfiche to all staff directly involved with student services. Date: _____