Severe Allergy Action Plan

Student's Name_____**D.O.B.**_____**Grade**_____

ALLERGY TO:_____

ASTHMA: YES / NO (Higher Risk For Severe Reaction)

STEP1: TREATMENT

SYMPTOMS:		**GIVE CHECKED MEDICATION** (**To be determined by physician authorizing treatment)	
□ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
□ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
□ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
□ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
□ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
□ Heart†	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
□ Other†	_____	☐ Epinephrine	☐ Antihistamine
□ If reaction is progressing (several of the above areas affected), give:		☐ Epinephrine	☐ Antihistamine

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

PHYSICIAN ORDERS:

Student May Self-Carry: ☐

Medication	Dosage/Route	Time (s)	Indications for Use
Epinephrine			
Antihistamine			
Other			

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Doctors Name (PRINT): _____ Phone Number: _____

Doctor's Signature: _____ Date:_____

(Required)

STEP 2: EMERGENCY CALLS (To be completed by Parent/Guardian)

1. Call 911: ***State that an allergic reaction has been treated, and additional epinephrine may be needed.***
2. Parents_____ Phone Number(s)_____
3. Emergency contacts:
   Name/ Relationship Phone Number(s)
   a._____(1)_____(2)_____
   b._____(1)_____(2)_____

EVEN IF PARENT/ GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO A MEDICAL FACILITY!

I hereby authorize the school district staff members to take whatever action, in their judgement, may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and the field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

ADULT MUST PICK UP UNUSED MEDICATION AT THE END OF THE SCHOOL YEAR

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Parent/Guardian Signature: _____ Date: _____

HISTORY OF ALLERGY REACTION (To be Completed by Parent/Guardian)

Allergic To: _____ Age discovered _____

Allergy Reaction was caused when substance was: (CIRCLE) Eaten Touched Inhaled Other:_____

Describe what happened (list symptoms): _____

_____

_____

Was an emergency epinephrine injection (EpiPen) used for the allergy reaction? (CIRCLE) Yes No

Was student treated in an ER or hospitalized for an allergy reaction? (CIRCLE) Yes No

If so, when? _____

Do you take any special precautions to reduce student's risk of any allergy reaction? _____

_____

_____

LOCATION OF MEDICATION (To be completed by GPISD Nurse)

- Student to carry _____
- Health Office/Designated Area for Medication _____
- Other: _____

LEVEL II TRAINED STAFF
