

# BERLIN BROTHERSVALLEY S.D.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School Year: \_\_\_\_\_

School Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**Allergy To:** \_\_\_\_\_ **Asthmatic:**  YES  NO

**STEP 1: TREATMENT – To be completed by Physician**

Symptoms:	Give checked Medication (to be determined by Physician)	
If exposure to an allergen occurs, but no symptoms	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Mouth: itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Skin: Hives, itchy rash, swelling of face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Throat: tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Lungs: shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Heart: weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Other * Call 911 an Parent	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
If reaction is progressing (several of the above areas affected)	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

\*Potentially Life-threatening, the severity of symptoms can quickly change.

Epinephrine-inject intramuscularly	<input type="checkbox"/> Epi-Pen 0.3mg	<input type="checkbox"/> Epi-Pen JR. 0.15 mg
Antihistamine	<input type="checkbox"/> Benadryl	Dose _____ mg

Repeat Epi-Pen  YES  NO in 15 minutes if EMS has not arrived -2 kits will be needed in school

**STEP 2: EMERGENCY CALLS**

**CALL 911/ TRANSPORT PATIENT TO THE ER**

**ALERT EMERGENCY CONTACTS**

Mother: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Father: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Other: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE