For Office Use Only: Grade/Teacher: _____
Location of medication:
Health Room Student Bus Other_____

ALLERGY Emergency Action Plan – Kershaw County School District

Student: _____ DOB: _____

Emergency Contact Name: _____Relationship: _____
Home: _____ Work: _____Cell: _____

Preferred Emergency Facility or Hospital: _____

Other Medical Diagnoses: _____ Asthma: ☐ NO ☐ YES (higher risk for severe reaction)

Weight: _____

ALLERGY: (check appropriate)

- Foods (list):_____
- Medications (list):_____
- Latex
- Stinging Insects (list):_____
- Other:_____

What happens during a reaction? ☐ hives ☐ swelling ☐ itching ☐ difficulty breathing ☐ other_____

Reactions have occurred from: (check all that apply) ☐ eating ☐ touching ☐ smelling ☐ other:_____

Has he/she had any serious reactions? ☐ NO ☐ YES How many? _____ Date of last event: _____

****

THIS SECTION TO BE COMPLETED BY HEALTH CARE PRACTITIONER

TREATMENT OF ALLERGY EXPOSURE/SYMPTOMS

FOR EXPOSURE TO ALLERGEN BUT NO SYMPTOMS:	→	**DO WHAT IS CHECKED BELOW:** **(Health care Provider: please check desired measures for care when no symptoms present)** ☐ Observe Only ☐ Give Antihistamine ☐ Give Epinephrine ☐ Other:
FOR MILD SYMPTOMS ONLY: **SKIN:** A few hives, mild itching **GUT:** Mild nausea/stomach discomfort	→	**GIVE ANTIHISTAMINE** • Stay with child • Monitor • Notify parent
FOR ANY SEVERE SYMPTOMS AFTER EXPOSURE: **LUNGS**: Short of breath, wheezing, constant coughing **HEART**: Pale, blue, faint, weak, dizzy, confused **THROAT**: Tight, hoarse, trouble breathing/swallowing **MOUTH**: Tongue swelling, lip swelling **SKIN**: Hives all over body **GUT**: Severe abdominal cramps, vomiting, diarrhea **OR** a *combination* of symptoms from different body areas	→	**GIVE EPINEPHRINE IMMEDIATELY** then • Call 911 • Stay with child • Give antihistamine • Give bronchodilator (inhaler) if asthma • Notify parent * Inhalers and antihistamines are not to be depended upon to solely treat anaphylactic reactions. Symptoms can rapidly become more severe. When in doubt, use epinephrine.

MEDICATIONS/DOSES

TYPE OF MEDICATION	NAME	DOSE	ROUTE
EPINEPHRINE			

☐ **IF AVAILABLE, EPINEPHRINE DOSE MAY BE REPEATED IF SYMPTOMS PERSIST, WORSEN, OR REOCCUR** (Health care provider, please check if applicable)

ANTIHISTAMINE			
OTHER:			

OVER

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ALLERGY Emergency Action Plan – Kershaw County School District

Student: _____ DOB: _____

IMPORTANT REMINDERS

1. Give medication as directed by health care provider.
2. If skin exposure, flush well with cool water.
3. If insect sting, gently scrape out (don't squeeze) stinger and apply ice.
4. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
5. Call parents/guardian to notify of reaction, treatment, and student's health status.
6. Stay with student. Treat for shock. Prepare to do CPR.
7. Accompany student to ER if no parent/guardian available.
8. Notify School Nurse and Administrator. Document what you observed and what actions you took.

APPROVALS:

HEALTH CARE PROVIDER SIGNATURE: _____ **Phone**: _____ **Date**:_____

SCHOOL NURSE SIGNATURE: _____ **Phone**: _____ **Date**:_____

By signing this document, the parent/guardian and/or the student authorize sharing this information with school personnel who have a legitimate need for knowledge of the information.

PARENT SIGNATURE: _____ **Phone**: _____ **Date**:_____

Copies of this plan provided to: ☐ *Teachers* ☐ *Phys Ed/Coach* ☐ *Principal* ☐ *Main Office* ☐ *Bus Driver* ☐ *Related Arts*

☐ *Other:*_____

DATE	***NOTES***

OVER

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ALLERGY Emergency Action Plan – Kershaw County School District

Student: _____ DOB: _____

OVER