FORSYTH COUNTY SCHOOLS

School Allergy Action Plan

(To be completed by a licensed practitioner)

Student's Name: _____ Date of Birth: _____ FCS Student Number: _____

Diagnosis: _____ ICD Code: _____Date form Completed: _____

List all known allergies:

_____

_____

Asthmatic: ☐ **Yes*** ☐ **No** **Students with asthma may be at higher risk for severe allergic reactions.*

Note: Asthma inhalers and antihistamines do not replace epinephrine for the treatment of anaphylaxis.

	MILD SYMPTOMS	SEVERE SYMPTOMS/ANAPHYLAXIS
Body System Symptoms	**Nose:** Itchy, runny nose, sneezing **Mouth:** Itchy mouth **Skin:** A few hives, localized rash or mild itching **Gut:** Mild nausea, discomfort or vomiting once.	**Lungs:** Shortness of breath, wheezing, repetitive cough **Heart:** Pale/bluish skin, weak pulse, dizziness, fainting, loss of consciousness **Throat:** Tight or hoarse throat, difficulty swallowing or breathing **Mouth:** Swelling of lips or tongue **Skin:** Widespread hives, rash or redness **Gut**: Repeated vomiting, severe diarrhea **Other:** Anxiety, confusion or sense of impending doom.
Action	**Administer antihistamine:** _____ **Name of Medication/Dose/Route**	**Administer epinephrine immediately:** _____ **Name of Medication/Dose/Route**
Monitor/Next Steps	**Monitor:** Remain with student, monitor closely and notify parent or guardian. ***If symptoms worsen or involve more than one body system, treat as Severe Symptoms/ Anaphylaxis.***	**Emergency Response:** • Call 911/activate EMS immediately after epinephrine is administered. Inform emergency personnel that epinephrine was administered for a suspected anaphylactic reaction. • Notify the parent/guardian. • Stay with the student until EMS arrives. • Monitor breathing, responsiveness and symptoms. • Administer a second dose of epinephrine if symptoms persist or worsen, according to licensed practitioner instructions.

Daily maintenance medications administered at home include: _____

Name of Medication/ Dose / Route

_____ Licensed Practitioner Name (PRINT)	_____ Parent Name (PRINT)
_____ Licensed Practitioner Signature & Credentials	_____ Parent Signature
_____ Date	_____ Date
Licensed Practitioner Office Stamp:	By signing above, I authorize Forsyth County School employees to contact my child's healthcare providers and/or pharmacy to obtain medical information related to my child's diagnosis, medications, treatments or any additional care required.