



# ALLERGY EMERGENCY PLAN

SCHOOL YEAR: \_\_\_\_\_

Parent may provide a student photo in this space

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Allergy to : \_\_\_\_\_

Asthmatic: Yes \* No  \*Children with asthma have a high risk for severe reaction

Date of last reaction: \_\_\_\_\_ Describe reaction seen: \_\_\_\_\_

### Emergency contact information:

Mother:	Home #:	Work #:	Cell #:
Father:	Home #:	Work #:	Cell #:
Other Emergency contact:	Home #:	Work #:	Cell #:
Other Emergency contact:	Home #:	Work #:	Cell #:

### SIGNS OF AN ALLERGIC REACTION:

- MOUTH itching & swelling of the lips, tongue and mouth
- THROAT\* itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- SKIN hives, itchy rash, and/or swelling about the face or extremities
- GUT nausea, abdominal cramps, vomiting and/or diarrhea
- LUNG\* shortness of breath, repetitive coughing, and/or wheezing
- HEART\* "thready pulse, "passing -out"

The severity of symptoms can quickly change. \*Any of the above symptoms can potentially progress to a life-threatening situation.

### • ACTION FOR A MINOR REACTION

Please describe what a minor reaction looks like for this student: \_\_\_\_\_

For a minor reaction, treatment is: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

(Any Benadryl or other medication for mild reaction needs to be provided to school with required documentation)

Then call: Mother  Father  Other contact: \_\_\_\_\_

*IF CONDITION DOES NOT IMPROVE OR CONDITION WORSENS, FOLLOW STEPS FOR MAJOR REACTION BELOW.*

### • ACTION FOR A MAJOR REACTION

Please describe what a major reaction looks like for this student: \_\_\_\_\_

If a severe reaction is suspected, treatment is: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

(Any Epi-Pen, Benadryl or other medication for major reaction needs to be provided to school with required documentation)

**CALL 911 IF A SEVERE REACTION IS SUSPECTED OR WHEN EPIPEN IS GIVEN!**

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

Nurse Signature \_\_\_\_\_

Date \_\_\_\_\_