

ALLERGY EMERGENCY PLAN

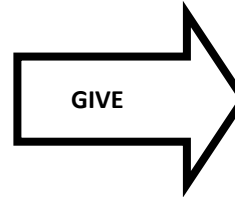


Student Name: _____ Student ID: _____ DOB: _____ School Name: _____ School Year: _____
 Parent Name: _____ Home: _____ Work: _____ Cell: _____
 Allergy to: _____ Describe: _____
 Asthmatic: *Yes (Children with asthma have a higher risk for severe reaction) No

DO NOT DEPEND ON ASTHMA INHALER AND/OR ANTIHISTAMINES TO TREAT ANAPHYLAXIS!!!

Antihistamines and Epinephrine Auto-injectors need to be provided to school by parents with required documentation.

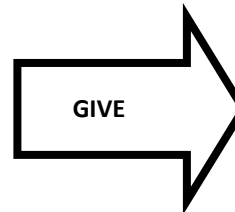
Minor Symptoms	Skin	<ul style="list-style-type: none"> Localized rash or hives or redness
	GI	<ul style="list-style-type: none"> Nausea or single episode of vomiting Abdominal pain



Med: _____ Dose: _____ by mouth
 (Name of Antihistamine, i.e. Benadryl, and dose)
WATCH CLOSELY FOR WORSENING SYMPTOMS

OR

Major Symptoms	Skin	<ul style="list-style-type: none"> Red, itchy rash around mouth or on face Itching of face with or without swelling Scattered hives over the body Eczema "flare-up"
	Respiratory	<ul style="list-style-type: none"> Hoarseness Stridor (Abnormal high pitched sound when breathing in) Difficulty breathing/shortness of breath Repeated coughing/wheezing Chest tightness
	GI	<ul style="list-style-type: none"> Repeated vomiting Drooling or difficulty swallowing
	Cardio-vascular	<ul style="list-style-type: none"> Weak, rapid pulse Lightheadedness or feeling faint Loss of consciousness



****GIVE EPINEPHRINE NOW****

Name of Injector: _____ Dose: _____
AND IF POSSIBLE GIVE
 Med: _____ Dose: _____ by mouth
 (Name of Antihistamine, i.e. Benadryl, and dose)

*****CALL 911*****

OPTION 1 OR 2 NEEDS TO BE COMPLETED AND SIGNED BY A PHYSICIAN IF STUDENT IS TO CARRY AND/OR SELF-ADMINISTER EPINEPHRINE:

1. I have instructed student in the proper use and dosage of his/her epinephrine auto-injector. It is my professional opinion that this student should be allowed to carry and self administer _____ (medication name and dose).
2. This student should be allowed to carry this epinephrine auto-injector while at school and on school bus. Student is not capable of administration of this medication _____ (medication name and dose).

Physician's Signature: _____ Date: _____

Parent Signature _____ Date _____

County School Nurse Signature _____ Date _____