

Severe Allergy Action Plan 2009-2010

Student's Name: _____ D.O.B: _____ Grade _____

Place Child's
Picture
Here

ALLERGY TO: _____

History of anaphylactic reaction: ___ Yes ___ No

Asthmatic: ___ Yes * ___ No *High risk for severe reaction

Number of hospital visits for an allergic reaction: _____ Date of last anaphylactic reaction: _____

Medication should be sent on field trips: ___ Yes ___ No

◆ STEP 1: TREATMENT ◆

Symptoms:

Give Checked Medication

Mouth	Itching, tingling, swelling of the lips, tongue or mouth
Skin	Hives, itchy rash, swelling of face or extremities
Gut	Nausea, abdominal cramps, vomiting, diarrhea
Throat *	Tightness of throat, hoarseness, hacking cough
Lung*	Shortness of breath, repetitive coughing, wheezing
Heart*	Thready pulse, low blood pressure, fainting, pale, blueness

(To be determined by physician authorizing treatment)

<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

Other _____

If reaction is progressing (several of the above areas affected), give

(The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation)

◆ DOSAGE ◆

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™0.3mg Twinject™0.15 mg

(See reverse side for instructions)

Antihistamine: give _____

Medication/dose/route/

repeat when?

Other: give _____

Medication/dose/route

repeat when?

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad : _____): State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____ Transport to: _____ Hospital

3. Emergency contacts:
Parents/Other

Phone Numbers(s)

a. _____ 1.) _____ 2.) _____

b. _____ 1.) _____ 2.) _____

c. _____ 1.) _____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

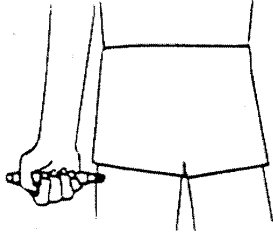
(Required)

EPIPEN® AND EPIPEN® JR. DIRECTIONS

1. Pull off gray activation cap.



2. Hold black tip near outer thigh (always apply to thigh).



3. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and discarded. Massage the injection area for 10 seconds.

◆ I give the Licensed School Nurse permission to consult (both verbally and in writing) with the above named student's physician regarding any questions that arise about the medical condition and/or medications/treatments/procedures being used to treat the condition. ___yes ___no

- Parent signature: _____ Date: _____
- School Nurse: _____ Date: _____

For Licensed School Nurse Use Individuals Trained

- | | |
|----------|-------------|
| 1. _____ | Date: _____ |
| 2. _____ | Date: _____ |
| 3. _____ | Date: _____ |
| 4. _____ | Date: _____ |
| 5. _____ | Date: _____ |
| 6. _____ | Date: _____ |
| 7. _____ | Date: _____ |
| 8. _____ | Date: _____ |

- The school district intends to use the requested information to provide for your child's health and safety needs while at school.
- You may refuse to supply the requested personal information.
- If this form is not completed it may result in an incomplete health and safety plan for you child.
- Medications are not administered at school without physician and parent signatures.
- The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success. (MS Section 13.04, Subdivision 2)