

EMERGENCY ACTION PLAN

Severe Allergic Reaction

Student Name: _____ DOB: _____ Grade/Teacher: _____
 Student is allergic to: _____

EMERGENCY CONTACT INFORMATION

Parents/Guardians:	Phone #1:	Phone #2:	Phone #3:
Alternate Contact:	Phone #1	Phone #2:	Phone #3:

If the School Nurse is in the building please notify nurse immediately!

IF YOU SEE THIS:	DO THIS:
<p><u>Mild Symptoms:</u></p> <ul style="list-style-type: none"> -Nose- itchy, runny nose & sneezing -Skin- a few hives, mild itch -Mouth- itchy mouth -Gut- mild nausea/discomfort 	<ul style="list-style-type: none"> *If school nurse is in the building please notify immediately. *Keep student calm and remain with student. *Student has _____ <i>(Medication)</i> at school that should be administered immediately *Call Parent *Watch student closely for changes. If symptoms worsen, give Epinephrine (if ordered). <i>(*If insect sting apply ice)</i>
<p><u>More Severe Symptoms:</u></p> <ul style="list-style-type: none"> -Lung- short of breath, wheezing, repetitive cough -Heart- pale, blue, faint, weak pulse, dizzy -Throat- tight, hoarse, trouble breathing/ Swallowing -Mouth- Significant swelling of tongue &/or lips -Skin- many hives over body, widespread redness -Gut- repetitive vomiting or severe diarrhea -Other- feeling something bad is about to happen, anxiety, confusion <p style="text-align: center;"><i>May have a combination of mild or severe symptoms from different body areas</i></p>	<ul style="list-style-type: none"> * Notify school nurse immediately if in the building *Activate Code Blue and CALL 911 and parent *Student has Epinephrine ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>If YES- then INJECT EPINEPHRINE IMMEDIATELY!</u> *Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side. *If symptoms do not improve, or symptoms return, sometimes a second dose of Epinephrine can be given *Transport student to ER even if symptoms resolve.

I understand and agree that information in this Emergency Action Plan will be shared with appropriate school staff.

Parent/Guardian Signature

Date

School Nurse Received and Reviewed: _____

School Nurse Signature

Date

To Be Completed By School Nurse

Location of medicine _____ **Authorized person to give medicine** _____

Student Name: _____ D.O.B. _____ Grade: _____ Teacher: _____

ALLERGY TO: _____ Bus #: _____

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems:

Symptoms:

- MOUTH** itching & swelling of the lips, tongue, or 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. All above symptoms can potentially progress to a life-threatening situation!

PLAN OF ACTION:

1. If systemic allergic reaction is suspected, give _____ IMMEDIATELY!
medication/dose/route
2. CALL 911
3. CALL: Parent/Guardian _____ or emergency contacts.
4. CALL: Dr. _____ at _____

If parent /legal guardian not available:

EMERGENCY CONTACTS

1. _____


Relation: _____ Phone: _____

2. _____

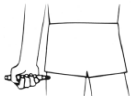
Relation: _____ Phone: _____

EPIPEN® AND EPIPEN® JR. DIRECTIONS

1. Pull off gray safety cap



2. Place black tip on outer thigh (always apply to thigh)



3. Using a quick motion, press hard into 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.

DO NOT HESITATE TO ADMINISTER MEDICATION AND CALL 911

Parent Signature

Date

School Nurse Signature Date

Medication order from a licensed provider on file. ___ YES

Location of EpiPen® 1. _____

Expires: _____

Trained Staff Members: 1. _____

2. _____

3. _____