Return To School Nurse

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:
Mild Symptoms: **-Nose- itchy, runny nose & sneezing** **-Skin- a few hives, mild itch** **-Mouth- itchy mouth** **-Gut- mild nausea/discomfort**	***If school nurse is in the building please notify immediately.** ***Keep student calm and remain with student.** ******Student has* ____________________ *(Medication)* ***at school that should be administered immediately*** ***Call Parent** ***Watch student closely for changes. If symptoms worsen, give Epinephrine (if ordered).** ***(*If insect sting apply ice)***
More Severe Symptoms: **-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** ***May have a combination of mild or severe symptoms from different body areas***	*** Notify school nurse immediately if in the building** ***Activate Code Blue and CALL 911 and parent** ***Student has Epinephrine ordered? □ Yes □ No** **If YES- then INJECT EPINEPHRINE IMMEDIATELY!** ***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*** ____________________

Feb 2016- Yellow

Student Name:____________________________D.O.B._______Grade: _____Teacher:_________

ALLERGY TO:____Bus #:____

SIGNS OF AN ALLERGIC REACTION INCLUDE:
Systems: **Symptoms:**

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.__________________