LAWRENCE PUBLIC SCHOOLS

EMERGENCY ALLERGY ACTION PLAN
SCHOOL YEAR_________

STUDENT'S NAME:____

ALLERGIC TO:____ Place Child's Picture

D.O.B.________________TEACHER______________________ROOM___________

Asthmatic_ Yes* ______ No______ *High risk for severe reaction

Symptoms:

Give Medications checked "X"

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

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

1. If ingestion is suspected and/or symptoms are:

____,

Give ____**IMMEDIATELY!**
medication/dose/route

Then call:

2. Rescue Squad (**inform them of type of emergency and ask for advanced life support**).

3. Parent/Guardian ____ or
emergency contacts.

4. Dr.____at___________________________

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent/Guardian's Signature____Date_________

Physician's Signature____Date_________

NOTE: ________CHECK HERE IFADDITIONAL PHYSICIAN'S INFORMATION IS INCLUDED ON REVERSE SIDE OF THIS SHEET

ADDITIONAL PHYSICIAN'S INFORMATION

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Physician's Signature **Date**