WARREN CONSOLIDATED SCHOOLS

Student: _____

Grade: _____ Teacher: _____

School: _____

School Phone: _____

School Fax: _____

SEVERE ALLERGY ACTION PLAN

PHYSICIAN

Student's Name: _____ Date of Birth: _____

Allergy To: _____

Asthmatic: YES / NO If yes, more chance of severe reaction.

Step 1 Treatment

Symptoms * **Potentially Life Threatening:** *severity of symptoms can quickly change*	Epinephrine	Antihistamine
If an allergen has been ingested, but NO symptoms	☐	☐
Mouth: itching, tingling, or swelling of lips, tongue, mouth	☐	☐
Skin: hives, itchy rash, swelling of the face or extremities	☐	☐
Gut: nausea, abdominal cramps, vomiting, diarrhea	☐	☐
* Throat: tightening of throat, hoarseness, hacking cough	☐	☐
* Lung: shortness of breath	☐	☐
* Heart: weak or thready pulse, low blood pressure, fainting, pale, blueness	☐	☐
If reaction is progressing (several of the above areas affected)	☐	☐

Emergency Action Steps: DO NOT HESITATE TO GIVE EPINEPHRINE!

Inject epinephrine in thigh. Epinephrine Brand: _____ Dose: 0.15 mg IM ☐ 0.3 mg IM ☐

Antihistamine: _____ Dose: _____ Route: _____

Other: _____ Dose: _____ Route: _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in Anaphylaxis (severe, life-threatening allergic response)

Imprint Physician Office Stamp Below:

Physician Signature: _____

Physician Phone Number: _____ Date: _____

PARENT

1. Call 911. State: "There is a medical emergency at _____ school. A severe allergic reaction has been treated. Additional epinephrine may be needed. Send EMS immediately." Stay on the line until 911 operator hangs up.

Step 2 Emergency Calls

2. Dr. _____ Physician Phone: _____
3. Parent: _____ Phone: _____ Phone: _____
4. Emergency Contact #1: _____ Phone: _____ Phone: _____
5. Emergency Contact #2: _____ Phone: _____ Phone: _____

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

I give consent to the release of information to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also authorize reciprocal release of information related to severe allergies between the school nurse and the health care provider.

Parent/Guardian Signature: _____ Date: _____

Updated: 8/12/20