

**WARREN  
CONSOLIDATED  
SCHOOLS**

Student: \_\_\_\_\_  
 Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
 School: \_\_\_\_\_  
 School Phone: \_\_\_\_\_  
 School Fax: \_\_\_\_\_

# SEVERE ALLERGY ACTION PLAN

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Allergy To: \_\_\_\_\_

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



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

**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: \_\_\_\_\_

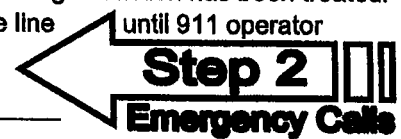
**IMPORTANT:** Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in Anaphylaxis (severe, life-threatening allergic response)

*Imprint Physician Office Stamp Below:*

Physician Signature: \_\_\_\_\_

Physician Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_

**PHYSICIAN**



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.

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: \_\_\_\_\_

**PARENT**