



# ALLERGY EMERGENCY PLAN

Student Name: \_\_\_\_\_ Student ID: \_\_\_\_\_ DOB: \_\_\_\_\_ School Name: \_\_\_\_\_ School Year: \_\_\_\_\_  
 Parent Name: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

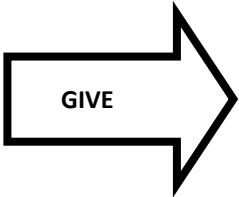
Allergic to: \_\_\_\_\_ Describe Symptoms: \_\_\_\_\_

Asthmatic:  **\*Yes** (Children with asthma have a higher risk for severe reaction)  **No**

**DO NOT DEPEND ON ASTHMA INHALER AND/OR ANTIHISTAMINES TO TREAT ANAPHYLAXIS!!!**

Antihistamines and Epinephrine Auto-Injectors need to be provided to school by parents with required documentation.

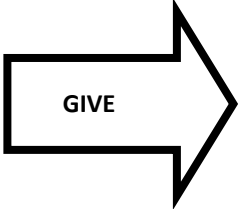
|                       |      |  |
|-----------------------|------|--|
| <b>Minor Symptoms</b> | Skin | <ul style="list-style-type: none"> <li>Localized rash or hives or redness</li> </ul>                           |
|                       | GI   | <ul style="list-style-type: none"> <li>Nausea or single episode of vomiting</li> <li>Abdominal pain</li> </ul> |



Med: \_\_\_\_\_ Dose: \_\_\_\_\_ by mouth  
 (Name of Antihistamine, i.e. Benadryl, and dose)  
**WATCH CLOSELY FOR WORSENING SYMPTOMS**

**OR**

|                       |                 |  |
|-----------------------|-----------------|--|
| <b>Major Symptoms</b> | Skin            | <ul style="list-style-type: none"> <li>Red, itchy rash around mouth or on face</li> <li>Itching of face with or without swelling</li> <li>Scattered hives over the body</li> <li>Eczema "flare-up"</li> </ul>                                |
|                       | Respiratory     | <ul style="list-style-type: none"> <li>Hoarseness</li> <li>Stridor (Abnormal high pitched sound when breathing in)</li> <li>Difficulty breathing/shortness of breath</li> <li>Repeated coughing/wheezing</li> <li>Chest tightness</li> </ul> |
|                       | GI              | <ul style="list-style-type: none"> <li>Repeated vomiting</li> <li>Drooling or difficulty swallowing</li> </ul>   |
|                       | Cardio-vascular | <ul style="list-style-type: none"> <li>Weak, rapid pulse</li> <li>Lightheadedness or feeling faint</li> <li>Loss of consciousness</li> </ul>   |



**\*\*GIVE EPINEPHRINE NOW\*\***

Name of Injector: \_\_\_\_\_ Dose: \_\_\_\_\_

**AND IF POSSIBLE GIVE**

Med: \_\_\_\_\_ Dose: \_\_\_\_\_ by mouth  
 (Name of Antihistamine, i.e. Benadryl, and dose)

**\*\*\*CALL 911\*\*\***

**OPTION 1 OR 2 NEEDS TO BE COMPLETED AND SIGNED BY A PHYSICIAN IF STUDENT IS TO CARRY AND/OR SELF-ADMINISTER EPINEPHRINE:**

1. I have instructed student in the proper use and dosage of his/her epinephrine auto-injector. It is my professional opinion that this student should be allowed to carry and self administer \_\_\_\_\_ (medication name and dose).
2. This student should be allowed to carry this epinephrine auto-injector while at school and on school bus. Student is not capable of administration of this medication \_\_\_\_\_ (medication name and dose).

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
 Parent Signature Date

\_\_\_\_\_  
 County School Nurse Signature Date