



ALLERGY EMERGENCY PLAN

SCHOOL YEAR: _____

Parent may provide a student photo in this space

Student Name: _____ DOB: _____

School: _____ Student ID: _____

Allergy to : _____

Date of last reaction and description: _____

Asthmatic: Yes * No *Children with asthma have a high risk for severe reaction

Mother:	Home #:	Work #:	Cell #:
Father:	Home #:	Work #:	Cell #:
Other Emergency contact:	Home #:	Work #:	Cell #:
Other Emergency contact:	Home #:	Work #:	Cell #:

SIGNS OF AN ALLERGIC REACTION:

- MOUTH itching & swelling of the lips, tongue and 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. *Any of the above symptoms can potentially progress to a life-threatening situation.

• ACTION FOR A MINOR REACTION

Please describe what a minor reaction looks like for this student: _____

For a minor reaction, treatment is: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

(Any Benadryl or other medication for mild reaction needs to be provided to school with required documentation)

Then call: Mother Father Other contact: _____

IF CONDITION DOES NOT IMPROVE OR CONDITION WORSENS, FOLLOW STEPS FOR MAJOR REACTION BELOW.

• ACTION FOR A MAJOR REACTION

Please describe what a major reaction looks like for this student: _____

If a severe reaction is suspected, treatment is: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

(EpiPen, Benadryl or other medication for major reaction needs to be provided to school with required documentation)

CALL 911 IF A SEVERE REACTION IS SUSPECTED OR WHEN EPIPEN IS GIVEN!

Copy of this plan has been provided to Transportation Supervisor Yes No

Parent Signature

Date

County School Nurse Signature

Date