

# EMERGENCY ACTION PLAN: SERIOUS ALLERGY

STUDENT: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CENTER NAME: \_\_\_\_\_ RM#: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Type of reaction: Anaphylaxis ( ) Other ( ) \_\_\_\_\_

Asthmatic? Yes ( ) No ( )

## SYMPTOMS:

## EMERGENCY TREATMENT: to be completed by physician

### MILD SYMPTOMS (Local reaction):

\*Mild Skin Reactions Hives/Swelling only in the areas of allergen contact.



Students with an Epi-pen or history of anaphylaxis must go home with parental supervision for the remainder of the school day.

**SYMPTOMS CAN BECOME MORE SERIOUS VERY QUICKLY OR OVER THE NEXT SEVERAL HOURS.**



### **IF STUDENT HAS MILD SYMPTOMS OR INGESTION IS SUSPECTED:**

- CALL 911.
- Note time and stay with student.
- **Watch closely for serious symptoms.**
- Give \_\_\_\_\_ as ordered by doctor.
- Call parent or emergency contact.
- Stay with student until parent or EMS arrives.
- Call school nurse.

**DO NOT HESITATE TO CALL 911 OR TO GIVE EMERGENCY MEDICATION(S).**

### SERIOUS SYMPTOMS (Systemic Reaction):

\* **Skin** widespread hives and flushing, widespread swelling  
\* **Mouth** swelling of the tongue  
\* **Throat** itching, or a sense of tightness of the throat, hoarseness, hacking cough  
\* **Gut** vomiting, nausea, cramps, diarrhea  
\* **Lungs** repetitive coughing, wheezing, trouble breathing  
\* **Heart** rapid heart rate, lightheadedness, dizziness, loss of consciousness



### **IF STUDENT HAS ANY SERIOUS SYMPTOMS:**

- Note time and stay with student.
- Give \_\_\_\_\_ as ordered by doctor.
- **Administer Epi-Pen.** Follow directions on injection device as trained. Note time given.
- **Call 911: Ask for Advanced Life Support for an Allergic reaction.**
- Call Parent or emergency contacts.
- Call School Nurse.

## THIS SECTION TO BE FILLED OUT BY THE PARENT



A separate current medication permission slip must be completed if medication is part of this plan.



This "Emergency Action Plan" will be available to staff who work closely with your child.



I understand that if any changes are needed on this Emergency Action Plan, it is the parent's responsibility to contact the nurse.

### **PLEASE COMPLETE THIS SECTION IF YOUR CHILD HAS A SEVERE FOOD ALLERGY**

Note: Meals from home provide the safest food option at school.

Check here if student will eat ANY school provided meals in the entire school year. **If so, the "Special Dietary Needs Application" MUST be completed.**

### **FOODS TO OMIT:**

\_\_\_\_\_  
\_\_\_\_\_



This Emergency Action Plan must be signed by both parent and physician.



My signature below shows I reviewed and agree with this plan.

Parent Signature

Date

Physician Signature

Date

School Nurse Signature

Date

Physician's Name Printed