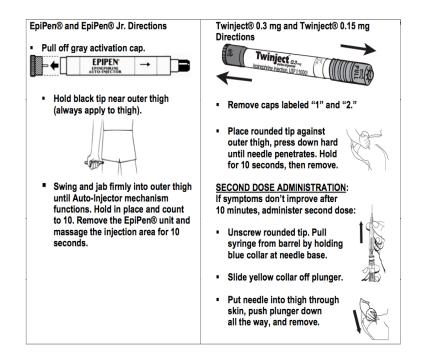
Allergic Reaction Emergency Action Plan

| Student: | tudent: Date of Birth: | | | | | | | | |
|--|---|--|--|---|--------|-------------------------|-------------------------------------|--|--------------|
| Grade: | Teacher: | | | | | | | | |
| Diagnosis of asthma: ☐ No ☐ Yes (associated with higher risk for severe reaction) | | | | | | | | | |
| My child's allergic reaction triggers are (please explain): ☐ Chocolate ☐ Almond ☐ Peanut ☐ Insect sting | | | | | | | | | |
| ☐ Food add ☐ Shellfish ☐ Vegetable Other (list): | ase list) itive e (please list) | ☐ Pecan ☐ Pistachio Nut ☐ Tree nut ☐ Walnut | ☐ Insect sting ☐ Latex Jut ☐ Medication (please list) ppy, sunflower, other) | | | | Place Student's Photo Here | | |
| RECOGNIT | ION AND TE | REATMENT | | | | | | | |
| To be completed by Health Care Provider ONLY | | | | | | Give CHECKED Medication | | | |
| If food ingested or contact with allergen occurs: | | | | | | EPI | PINEPHRINE A | | NTIHISTAMINE |
| 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, repetitive coughing, wheezing | | | | | | | | |
| HEART* | Thready pu | Thready pulse, low blood pressure, fainting, pale, blueish color | | | | | | | |
| NEURO* | NEURO* Disorientation, dizziness, loss of consciousness | | | | | | | | |
| If reaction is progressing (several of the above areas affected) GIVE: | | | | | | | | | |
| * POTENTIALLY LIFE THREATENING | | | | | | | | | |
| The severity of symptoms can quickly change. | | | | | | | | | |
| Epinephrine: ☐ EpiPen Jr.® ☐ EpiPen® ☐ Twinject® 0.15 mg ☐ Twinject® 0.3 mg Antihistamine (Benadryl®) ☐ 12.5 mg ☐ 25 mg ☐ 50 mg Other medication(s): | | | | | | | | | |
| EMERGENCY CONTACTS | | | | | | | | | |
| | | Name | | н | Home # | | Work # | | Cell # |
| Parent/Gu | ardian | | | | | | | | |
| Parent/Guardian | | | | | | | | | |
| Other: | | | | | | | | | |
| Other: | | | | | | | | | |
| Physician signature: Date: | | | | | | | | | |



Parent/Guardian Agreement and Authorizations

Nurse Signature: _

| $\ \square$ I will provide the school with any medication which my child requires for eme | rgency treatment. | | | | | | | |
|---|---------------------------------------|--|--|--|--|--|--|--|
| I will initiate a meeting with the school nurse and School Nutrition Director to determine menu options for my child who | | | | | | | | |
| has a food allergy. | | | | | | | | |
| I will educate my child in self-management of his/her food allergy including safe and unsafe foods, strategies for | | | | | | | | |
| avoiding exposure to unsafe foods, symptoms of an allergic reaction, and ho | w and when to tell an adult if he/she | | | | | | | |
| may be having an allergy related problem. | | | | | | | | |
| ☐ I want this allergy plan implemented for my child; I want my child to carry an auto-injector and I agree to release the | | | | | | | | |
| school district and school personnel from all claims of liability if my child suffe | ers any adverse reactions from self | | | | | | | |
| administration of an auto-injector. | | | | | | | | |
| ☐ I want this plan implemented for my child and I do not want my child to self-a | administer epinephrine. | | | | | | | |
| Your signature gives permission for the school nurse to contact and receive additional information from your | | | | | | | | |
| health care provider regarding the allergic condition(s) and the prescribed medication. | | | | | | | | |
| | | | | | | | | |
| Parent/Guardian Signature: | Date: | | | | | | | |
| Student Agreement | | | | | | | | |
| ☐ I have been trained in the use of my auto-injector and allergy medication and understand the signs and symptoms for | | | | | | | | |
| which they are given. | | | | | | | | |
| ☐ I agree to carry my auto-injector with me at all times. | | | | | | | | |
| ☐ I will notify a responsible adult (teacher, nurse, coach, etc.) IMMEDIATELY when my auto-injector is used. | | | | | | | | |
| ☐ I will not share my medication with other students, leave my auto-injector unattended, or use my auto-injector in an | | | | | | | | |
| inappropriate manner. | | | | | | | | |
| ☐ I will not use my allergy medications for any other use than what it is prescrib | ped for. | | | | | | | |
| | | | | | | | | |
| Student Signature: | Date: | | | | | | | |

Date: