

Student's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade: \_\_\_\_\_

Place child's photo here

School: \_\_\_\_\_ Teacher: \_\_\_\_\_

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

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

**Asthma:** YES (higher risk for severe reaction) – refer to their asthma care plan

**SEVERE SYMPTOMS:** Any of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Swelling of the tongue and/or lips
- HEART: Pale, blue, faint, weak pulse, dizzy
- SKIN: Many hives over body, widespread redness
- GUT: Vomiting or diarrhea (if severe or combined with other symptoms)
- OTHER: Feeling something bad is about to happen, Confusion, agitation

**MILD SYMPTOMS ONLY:**

- NOSE: Itchy, runny nose, sneezing
- SKIN: A few hives, mild itch
- GUT: Mild nausea/discomfort

**1. INJECT EPINEPHRINE IMMEDIATELY**

2. Call 911
  - Ask for ambulance with epinephrine
  - Tell EMS when epinephrine was given
3. Stay with child and
  - Call parent/guardian and school nurse
  - If symptoms don't improve or worsen give second dose of epi if available as instructed below
  - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinephrine. **USE EPINEPHRINE**

1. Stay with child and
  - Alert parent and school nurse
  - Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and follow directions in above box

Provider (print) \_\_\_\_\_ Phone Number: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**◇ STEP 2: EMERGENCY CALLS ◇**

1. If epinephrine given, **call 911**. State that an anaphylactic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: \_\_\_\_\_ Phone Number: \_\_\_\_\_
3. Emergency contacts: Name/Relationship                      Phone Number(s)
 

a. _____	1) _____	2) _____	
b. _____	1) _____	2) _____	

**DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS**

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Staff trained and delegated to administer emergency medications in this plan:**

1. \_\_\_\_\_ Room \_\_\_\_\_

2. \_\_\_\_\_ Room \_\_\_\_\_

3. \_\_\_\_\_ Room \_\_\_\_\_

Self-carry contract on file:      Yes      No

Expiration date of epinephrine auto injector: \_\_\_\_\_

If this conditions warrents meal accomodations from food service, please complete the form for dietary disabilitiy if required by district policy.