



School Year \_\_\_\_\_

**SEVERE ALLERGY ACTION PLAN**

**Student Name** \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Grad Year \_\_\_\_\_

School \_\_\_\_\_ Teacher/HR \_\_\_\_\_

**PARENT / GUARDIAN EMERGENCY CONTACT INFORMATION:**

**Please provide phone numbers in order of where we can reach you during the school day in case of emergency.**

Phone 1. _____	H/C/W _____	Name/Relationship _____
Phone 2. _____	H/C/W _____	Name/Relationship _____
Phone 3. _____	H/C/W _____	Name/Relationship _____
Phone 4. _____	H/C/W _____	Name/Relationship _____
Email for Health Plan updates: _____		

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

Physician student sees for Allergy \_\_\_\_\_ Phone \_\_\_\_\_

Asthmatic: Yes\_\_\_\_ No\_\_\_\_ (If yes, student has higher risk for a severe reaction)

Check the symptoms your child has during a severe allergic reaction:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Hives/Rash    | <input type="checkbox"/> Tightness in Chest    | <input type="checkbox"/> Difficulty Breathing         | <input type="checkbox"/> Nausea / Vomiting        |
| <input type="checkbox"/> Itching       | <input type="checkbox"/> Swelling<br>Arms/Legs | <input type="checkbox"/> Unconsciousness              | <input type="checkbox"/> Drooling                 |
| <input type="checkbox"/> Dizziness     | <input type="checkbox"/> Flushed Face          | <input type="checkbox"/> Cramping / Abdominal<br>Pain | <input type="checkbox"/> Swollen lips /<br>tongue |
| <input type="checkbox"/> Hacking Cough | Other: _____                                   |   |   |

Onset of symptoms after ingestion or contact:

- |                                      |   |  |   |   |
|--------------------------------------|---|--|---|---|
| <input type="checkbox"/> Immediately | <input type="checkbox"/> Within 15<br>minutes | <input type="checkbox"/> Within 1 hour | <input type="checkbox"/> Within 2 hours | <input type="checkbox"/> Varies/Unknown |
|--------------------------------------|---|--|---|---|

Does your child require an antihistamine at school? Yes\_\_\_\_ No\_\_\_\_  
Medications/Dose \_\_\_\_\_

**Does your child require Epinephrine at School?** Yes\_\_\_\_ No\_\_\_\_

Has your child ever needed epinephrine before? Yes\_\_\_\_ No\_\_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_

**NOTE:** Parents are responsible for providing medications given at school. A [Medication Authorization Form](#) needs to be filled out and signed by a parent/guardian and health care provider annually.

PLEASE COMPLETE AND SIGN NEXT PAGE →

Student Name \_\_\_\_\_

**EMERGENCY ACTION PLAN -STEPS TO TAKE DURING AN ALLERGIC REACTION**

**If you see this: Mild Reaction \_\_\_\_\_, Do This:**

- Have student come to the office/health room with an escort
- Call parent/guardian to inform them of situation and get permission to give antihistamine (such as Benadryl) Give \_\_\_\_\_ mg \_\_\_\_\_ antihistamine orally
- Locate the student's epinephrine pen or retrieve a STOCK EpiPen if theirs cannot be located
- Continue to monitor for 20-30 minutes and observe for signs and symptoms of **anaphylaxis**

**IF YOU SEE THIS: ANAPHYLAXIS, A SEVERE ALLERGIC REACTION**

**Mouth:** Itching, tingling, or swelling of the lips, tongue, or mouth.

**Throat:** Itching or tightening in the throat, hoarseness, hacking cough.

**Skin:** Hives, itchy rash, swelling of the face or extremities.

**Gut:** Nausea, abdominal cramps, vomiting, diarrhea.

**Lungs:** Shortness of breath, repetitive coughing, wheezing.

**Heart:** Weak or irregular pulse, low blood pressure, faintness, pale, blue



**DO THIS: FOR SEVERE ANAPHYLACTIC REACTION**

- **Call the school office to have the EpiPen brought to student immediately**
- **Have the office call a Medical Emergency Response and Call 911**
- **If the student does not have their EpiPen at school, use a STOCK EpiPen**
- **Administer the EpiPen immediately. May repeat with a second EpiPen after 5-20 minutes.**
  - √ Dispose of needle and injector in a red sharps container
  - √ Give EpiPen package and a copy of this health plan to rescue personnel
- Notify parent/guardian (EpiPen administration and calling 911 take priority over parent notification)
- Notify building principal and school nurse, if not already aware
- Complete an [Accident/Incident Report](#) and [Medical Emergency Response Team Report](#)

Memo of Understanding:

- It is understood that a parent will complete and sign a Severe Allergy Action Plan annually.
- It is understood that a parent will provide emergency medications needed at school.
- It is the responsibility of the parent to notify the school nurse of any changes in the health plan.

This plan and medication will be used in case of emergency and accompany student off school property. This information may be shared with the classroom teacher(s), administrators, aides, bus driver, and other appropriate school personnel with a need to know.

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

School Nurse: \_\_\_\_\_ Anna Lisiecki, BSN, RN