SCHOOL DISTRICT OF THORP
Student Health Services

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:

- ☐ Hives/Rash
- ☐ Itching
- ☐ Dizziness
- ☐ Hacking Cough
- ☐ Tightness in Chest
- ☐ Swelling Arms/Legs
- ☐ Flushed Face
- ☐ Difficulty Breathing
- ☐ Unconsciousness
- ☐ Cramping / Abdominal Pain
- ☐ Nausea / Vomiting
- ☐ Drooling
- ☐ Swollen lips / tongue

Other: _____

Onset of symptoms after ingestion or contact:

☐ Immediately ☐ Within 15 minutes ☐ Within 1 hour ☐ Within 2 hours ☐ 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 REATION

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 ALLERGICE 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 SEVER 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.
- Is it 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: _____