

Edina Public Schools · Severe Allergy Action Plan 2010-2011
Please have physician complete this two page form.

Student's Name: _____ Date of Birth: _____ (Student Photo)
 School: _____ Grade: _____

Severe Allergy To: _____

Asthmatic: Yes * No * **High risk for severe reaction** **History of anaphylactic reaction:** Yes No

Date of last anaphylactic reaction: _____ # of hospital visits for allergic reaction: _____

Step 1: Treatment

Symptoms

- Mouth** Itching, tingling, swelling of the lips, tongue or mouth
- Skin** Hives, itchy rash, swelling of face or extremities
- Gut** Nausea, abdominal cramps, vomiting, diarrhea
- Throat *** Tightness of throat, hoarseness, hacking cough
- Lung*** Shortness of breath, repetitive coughing, wheezing
- Heart*** Thready pulse, low blood pressure, fainting, pale, blueness
- Other**

Give Checked Medication

(To be determined by physician authorizing treatment)

- | | |
|---|---|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

➢ If a food allergen has been ingested, but no symptoms: _____ **Epinephrine** **Antihistamine**

➢ If exposure to allergen other than by ingestion (skin/inhalation) _____ **Epinephrine** **Antihistamine**

If reaction is progressing (several of the above areas affected), give **Epinephrine** **Antihistamine**

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.

Medication and Dosage

Epinephrine: inject intramuscularly (circle one) EpiPen® 0.3mg EpiPen® Jr. 0.15mg Twinject™0.3mg Twinject™0.15mg

Antihistamine: give _____

Medication/dose/route/

repeat when?

Other: give

Medication/dose/route

repeat when?

Physician Signature (required) _____ **Date** _____

Print Physician/Clinic Name: _____ **Phone:** _____

Step 2: Emergency Calls

1. Call 911 immediately. 911 MUST BE CALLED if EpiPen is administered. State that an allergic reaction has been treated and additional epinephrine may be needed.

2. Dr. _____ **at** _____ **Transport to :** _____ **Hospital**

3. Emergency contacts:

Parents/Other

Emergency Phone Number(s)

1. _____ a) _____ b) _____

2. _____ a) _____ b) _____

3. _____ a) _____ b) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Authorization

1. I agree with the above Severe Allergy Action Plan and I request that the above medication/s be given during school hours as ordered by my child's physician/licensed prescriber.
2. I request that the above medication be sent on field trips. Yes No
3. I will notify the school if medication is stopped.
4. I give permission for the medication/s to be given by school personnel as delegated, trained, and supervised by the school nurse.
5. Legally I may refuse to sign the Severe Allergy Action Plan. If I refuse to sign, the district will not be able to administer the prescribed medication.
6. This consent may be revoked at any time by sending a written notice to the licensed school nurse.

Parent/Guardian Signature

Date

Permission for Release of Information

1. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition/s and the action of the medication/s.
2. I give permission for the school nurse to contact my child's physician/licensed prescriber regarding questions about the above listed medication/s or medical condition/s being treated by medication/s.

Parent/Guardian Signature

Date

School Nurse: _____ **Date:** _____

Health Associate: _____ **Date:** _____

**For Licensed School Nurse Use
Individuals Trained**

- | | |
|----------|-------------|
| 1. _____ | Date: _____ |
| 2. _____ | Date: _____ |
| 3. _____ | Date: _____ |
| 4. _____ | Date: _____ |
| 5. _____ | Date: _____ |