SEVERE ALLERGY INFORMATION

Student's Name:_____ Birthdate:_____

School:_____ Grade:_____

Allergies: (food, insects, medication, etc.)	Reaction
1.	1.
2.	2.
3.	3.

Diet Restrictions: For food allergies, parents will monitor school lunch menus or provide food, student will self monitor food choice; teacher will assist child unable to self select food choices.)

Medications used on a daily basis: (both at home and at school, include doses)

1._____ 2._____

3._____ 4._____

Reminder: Teachers or other trained personnel must take EpiPen® or any other medication on all field trips. School personnel should make sure phone is close by if needed. Keep EpiPen® at room temperature, DO NOT FREEZE, refrigerate, or keep in extreme heat.

Pertinent Health History (as completed by school nurse)_____

_____

_____

EMERGENCY INFORMATION

Father's/Guardian's name:

Address:
Home phone: Work phone:

Mother's Guardian's name:

Address:
Home phone: Work phone:

Alternate contact person if parent cannot be reached:

Name: Relationship:
Address:
Home phone: Work phone:

Name:
Address:
Home phone: Work phone:

Physician who should be called regarding allergic reaction:

Name:
Address: Phone:

Hospital Preference:

It is understood by parents and physicians this plan may be carried out by school personnel other than the school nurse. A Registered Nurse is to be responsible for delegation of this task to an unlicensed person.

Physician Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

School Nurse:_____ Date:_____

School Administrator:_____ Date:_____

FOOD ALLERGY ACTION PLAN

ALLERGY TO:_____

Student's Name_____D.O.B_____Teacher_____

Asthmatic Yes ☐ No ☐ *High risk for severe reaction

Systems:	Symptoms:
▪MOUTH	itching & swelling of the lips, tongue, or mouth
▪THROAT*	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
▪SKIN	hives, itchy rash, and/or swelling about the face or extremities
▪GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
▪LUNG*	shortness of breath, repetitive coughing, and/or wheezing
▪HEART*	"thready" pulse, "passing out"

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

ACTION FOR MINOR REACTION

1. If only symptom(s) are:_____; give _____
medication/dose route

_____

Then call:
2. Mother_____, Father_____, or emergency contacts
3. Dr._____ at _____

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION

1. If ingestion is suspected and/or symptom(s) are:_____
give _____IMMEDIATELY!
medication/dose/route

Then call:
2. Rescue Squad (ask for advanced life support)
3. Mother_____, Father_____, or emergency contacts.
4. Dr._____at_____

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent's Signature_____Date_____

Doctor's Signature_____Date_____