ALLERGY Emergency Action Plan

Keller ISD Health Services Department

NAME: _____DOB:_____Teacher/Grade: _____

Emergency Contact #1:_____ Preferred Contact # _____
Emergency Contact #2:_____ Preferred Contact # _____
Physician Treating Allergy: _____ Preferred Contact # _____
Preferred Hospital: _____

Diagnosis/Condition: **ALLERGY** **Extremely reactive to following: _____**
Is the allergy life threatening? ☐YES/ ☐NO Will Epinephrine be provided?☐YES/☐ NO
Date of last reaction? _____ ***If yes, parent must provide Epi-Pen/Epinephrine RX***
Symptoms exhibited _____ Does student have Asthma?☐YES/☐NO

_____ Triggers? _____

MEDICATIONS FOR ALLERGY TO BE ADMINSTERED AT SCHOOL: (Medication Authorization Form required)

	Medication	Dosage	Route
Epinephrine:			
Antihistamine:			
Other:			

This section is to be completed by Physician ONLY

Extremely reactive to the following: _____

If checked, give epinephrine immediately for **ANY** symptoms if known or suspected contact with allergen.

If checked, give epinephrine immediately if ***definite*** contact with allergen, even if no symptoms present.

Any SEVERE SYMPTOMS after suspected or known contact:
One or more of the following:
Lungs: Shortness of breath, wheeze, repetitive cough
Heart: Pale, blue, faint, weak pulse, dizzy, confused
Throat: Tight, hoarse, trouble breathing/swallowing
Mouth: Obstructive swelling (tongue or lips)
Skin: Many hives over body, redness/warmth

Or combination of symptoms from different body areas:
Skin: Hives, itchy rashes, swelling (eyes, lips)
Gut: Vomiting, diarrhea, crampy pain

1. Immediately give Epinephrine
2. Call 911
3. Monitor student
4. Give additional medications*

*A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.

Mild symptoms only:
Mouth: itchy mouth
Skin: a few hives around mouth/face, mild itch
Gut: mild nausea/vomiting

1. Give antihistamine
2. Stay with student, call parents
3. If symptoms worsen, give Epinephrine
4. Monitor student

Physician Signature: _____Date: _____

Student's Name: _____ **DOB**: _____

DIAGNOSIS/CONDITION: **ALLERGY** **ALLERGEN: _____**

Additional Information

EPI-PEN/EPINEPHRINE INFORMATION: (always call **911** if Epinephrine administered)

Epinephrine location	
Trained staff/location	
Trained staff/location	
Buddy Nurse/location	
Other:	

For all devices attach the Epi Trainer user guide (located on the Health Services website).

Acknowledged and Received by:

Parent Signature: _____Date: _____
RN Signature: _____Date: _____
LVN Signature: _____Date: _____

☐ Allergy EAP electronically sent via Laserfiche to all staff directly involved with student services. Date: _____