



# 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: \_\_\_\_\_

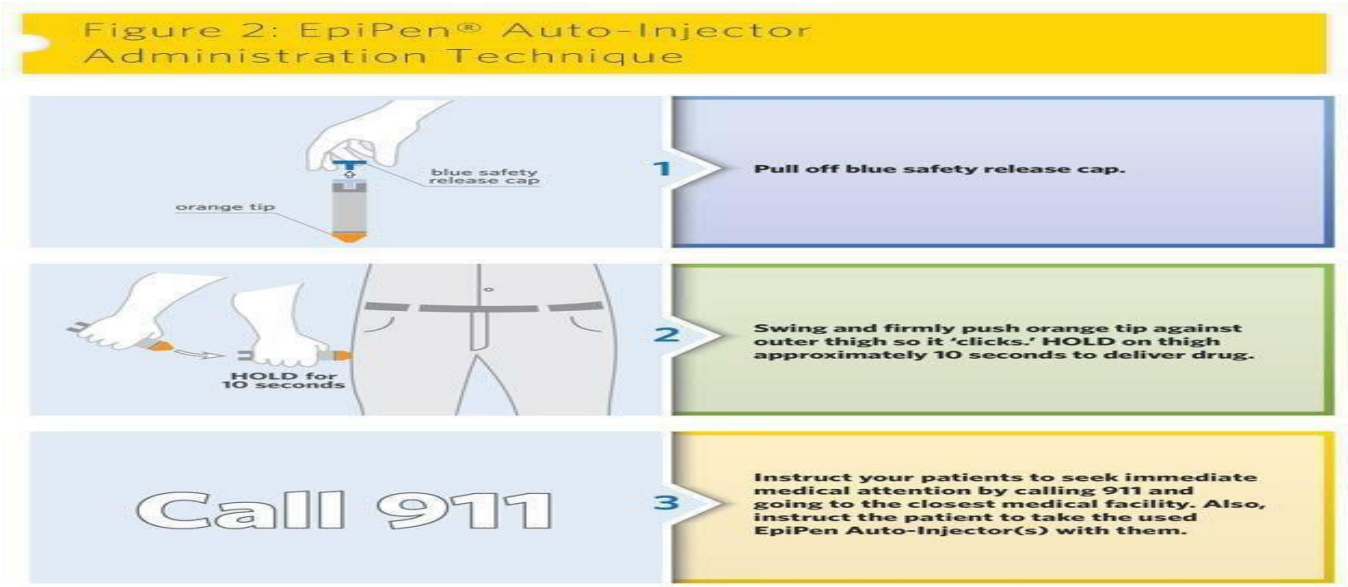
DOB: \_\_\_\_\_

DIAGNOSIS/CONDITION: **ALLERGY**  
Additional Information

ALLERGEN: \_\_\_\_\_

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

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



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For devices other than Epi-Pen, attach training steps.

Acknowledged and Received by:

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

RN Signature: \_\_\_\_\_ Date: \_\_\_\_\_

LVN Signature: \_\_\_\_\_ Date: \_\_\_\_\_