HCPS
Henrico County Public Schools

SEVERE ALLERGY ACTION PLAN
ALLERGIC TO: _____
(Nurse use to communicate with Physician and Parent)

Place Child's Picture Here (optional)

Student's Name_____
DOB:_____
Date:_____

♦ **SIGNS OF AN ALLERGIC REACTION** ♦

Systems	Symptoms	☐ If checked, this student has asthma and the likelihood of anaphylaxis is increased.
♦ **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 **symptom**(s) are (list): _____
   give _____.
   - If condition does not improve within 10 minutes, follow steps for Major Reaction below.
2. **Call:** Mother_____ Father _____or emergency contact.

♦ **ACTION FOR MAJOR REACTION** ♦

1. If symptom(s) are (list): _____
   give _____**IMMEDIATELY!**
2. **Call:** Rescue Squad (ask for advanced life support).
3. **Call:** Mother_____Father_____or emergency contact.

DO NOT HESITATE TO CALL RESCUE SQUAD!!!

INSTRUCTIONS FROM PHYSICIAN:

☐ I have instructed this student in the proper use of his/her emergency medication for anaphylaxis. This student should be able to carry and use this medication at school independently.

☐ This student needs assistance using his/her emergency medication for anaphylaxis in school.

_____

Physician Signature **Phone Number** **Date**

PARENT PERMISSION:

By signing this form, I give permission for the school to use the above plan to manage my child's severe allergy. The school may contact my child's physician regarding severe allergy. I understand that I may request to meet with the counselor to discuss educational accommodations that may be needed in the school setting.

_____ _____ _____ _____

Parent Signature **Date** **RN Signature** **Date**