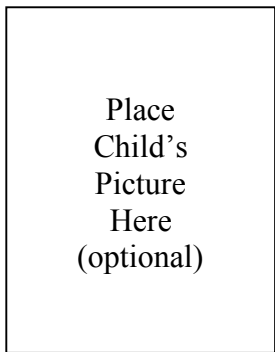




SEVERE ALLERGY ACTION PLAN
ALLERGIC TO: _____
(Nurse use to communicate with Physician and Parent)



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