<<School Name>> Health Office <<School Address>> <<School City State>>

EMERGENCY PROCEDURES: ALLERGY ACTION PLAN

I hereby authorize and request that the school nurse do the following procedures for :

Student: < <last name="">> Date of Birth:<<date birth="" of="">></date></last>	>, <<first b="" na<=""> Grade:<<grade:< th=""><th></th><th></th><th></th></grade:<></first>			
ALLERGY TO:	· · · · · · · · · · · · · · · · · · ·			
AsthmaticNOYES	**Higher risk for	severe reaction		
Symptoms:			ive Checked Medica	
If a food allergen has been ingested, bu Skin Hives, itchy rash, swelling of the fa Gut Nausea, abdominal cram Throat** Tightening of throat, hoa Lung** Shortness of breath, report Thready pulse, low blood Other** If reaction is progressing (several of the	ce or extremities ps, vomiting, diarrhearseness, hacking cou- etative coughing, whe pressure, fainting, pa- above areas affected		rmined by physician authorizir pinephrine Antihistar pinephrine Antihistar	mine mine mine mine mine mine mine mine
DOSAGE _ Epinephrine - (circle all that apply) Ep Antihistamine: give Benadryl 25m	i-Pen - repeat x1	Epi-Pen Jr - repeat x1	Twinject 0.3mg	Twinject 0.15 mg
Other: give	medication/dose/ro	oute		
Stron. give	medication/dose/ro	oute		
IMPORTANT: Asthma inhalers and/or a Student may self carry medications list				
EMERGENCY CALLS 1. Call 911 (or rescue squad:). State tha	-	as been treated, and	additional epinephrine
Even if parent/guardian cannot be re		sitate to medicate or ta	ke child to madical fa	acility!
Parent/Guardian Signature	Date			
Physician Signature	Date	School Nurse	Date	