Jefferson City School District
Health Services
EMERGENCY ACTION PLAN-ALLERGY & ANAPHYLAXIS

Name:_____ Student #:_____ D.O.B:_____

ALLERGY TO:_____

Asthmatic (circle one): Yes * No ***Higher risk for severe reaction**

Parent / Guardian 1: _____ Phone:_____
Parent / Guardian 2: _____ Phone:_____
Emergency Contact (If parent or guardian cannot be reached):_____ Phone:_____

If These Symptoms:	**Then Give Checked Medication:** (To be determined by provider authorizing treatment)
• If allergen has been ingested (food, sting), but *no symptoms*:	□ Epinephrine □ Antihistamine
• Mouth: Itching, tingling, or swelling of lips, tongue, mouth	□ Epinephrine □ Antihistamine
• Skin: Hives, itchy rash, swelling of the face or extremities	□ Epinephrine □ Antihistamine
• GI: Nausea, abdominal cramps, vomiting, diarrhea	□ Epinephrine □ Antihistamine
• Tightening of throat, hoarseness, hacking cough	□ Epinephrine □ Antihistamine
• Shortness of breath, repetitive coughing, wheezing	□ Epinephrine □ Antihistamine
• Thready pulse, low blood pressure, fainting, pale, blueness	□ Epinephrine □ Antihistamine
• Other _____	□ Epinephrine □ Antihistamine
• If reaction is progressing (several above areas affected), give	□ Epinephrine □ Antihistamine

Antihistamine to be given**:**

_____
Medication/Dose/Route

IN CASE OF SEVERE ALLERGIC REACTION:

Epinephrine: (Circle dose) EpiPen® 0.3 mg EpiPen® Jr 0.15 mg Auvi-Q® 0.3 mg Auvi-Q® 0.15 mg.

If epinephrine is administered, call 911. Send used epinephrine injection device with EMS.

Parent/Guardian Consent for Management of Allergic Reaction at School

I, the parent /guardian of the above named student, request that this emergency action plan be used to guide allergy care for my child. I agree to:

1. Provide necessary supplies and equipment.
2. Notify the school nurse of any changes in the student's health status.
3. Notify the school nurse and provide order changes from the student's healthcare provider.
4. Authorize the school nurse to communicate with the healthcare provider/specialist as needed.
5. School staff interacting directly with my child may be informed about his/her special needs while at school.

Parent/Guardian Signature: _____ Date: _____