SHARYLAND ISD
HEALTH SERVICES

ALLERGY (SEVERE) EMERGENCY ACTION PLAN

School Nurse:

Place child's picture here

PART I: TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: _____ DOB: _____/_____/_____

ID# _____ Grade/Teacher (if elem.): _____

School: _____ ◯ Drop off/pick up ◯ Bus rider: Bus # = ____ ◯ Walker

Parent(s)/Guardian(s):

Name/Relationship: Phone Number(s):

_____ Cell: ( ) _____ H: ( ) _____

_____ Cell: ( ) _____ H: ( ) _____

Preferred Hospital:_____

Emergency Contacts: (In the event that parent(s)/guardian(s) cannot be reached, please contact)

Name/Relationship: Phone Number(s):

_____ Cell: ( ) _____ H: ( ) _____

_____ Cell: ( ) _____ H: ( ) _____

Allergy to: _____

How does this allergy present itself physically in your child?_____

Asthma: _____ No _____ Yes (higher risk for severe reaction) **EpiPen in clinic**: _____ No

Yes

PART II: TO BE COMPLETED BY TEXAS-LICENSED PHYSICIAN
TREATMENT PLAN FOR ABOVE ALLERGY

* ***Also complete the Physician's Order for Medication Administration***.

Symptoms:	**Give checked medication(s):**		
• If exposed to allergen, but *NO* symptoms	◯ Epinephrine	◯ Antihistamine	◯ Nothing
• **Mouth**: itching, tingling, or swelling of lips, tongue, mouth	◯ Epinephrine	◯ Antihistamine	
• **Skin**: hives, itchy rash, swelling of the face or extremities	◯ Epinephrine	◯ Antihistamine	
• **Gut**: nausea, abdominal cramps, vomiting, diarrhea	◯ Epinephrine	◯ Antihistamine	
• **Throat***: tightening of throat, hoarseness, hacking cough	◯ Epinephrine	◯ Antihistamine	
• **Lung***: shortness of breath, repetitive coughing, wheezing	◯ Epinephrine	◯ Antihistamine	
• **Heart***: thread pulse, low blood pressure, fainting, pale, blueness	◯ Epinephrine	◯ Antihistamine	
• **Other***:	◯ Epinephrine	◯ Antihistamine	
• If reaction is progressing (several of the above areas affected), give…	◯ Epinephrine	◯ Antihistamine	
*** Potentially life-threatening. The severity of symptoms can change quickly.**			

DOSAGE: (Note: Parent MUST provide appropriate medication(s)/quantity to school nurse/personnel)

1. Epinephrine- Inject intramuscularly:
   _____ EpiPen _____ EpiPen Jr. _____ Twinject _____ Auvi-Q _____ Other: _____
2. Antihistamine:
   a. Give the following:
      Medication _____
      Dose _____ Route: _____
3. Other:
   a. Give the following:
      Medication _____
      Dose _____ Route: _____

   b. Give the following:
      Medication _____
      Dose _____ Route: _____

PLACE EMERGENCY CALLS (If Epipen has been administered, EMS MUST be called):

1. **CALL EMS/9-1-1**. State that an allergic reaction has been treated and additional Epinephrine may be needed.
2. Call Dr. _____ at ( ) _____.
3. **IF PARENT/GUARDIAN CANNOT BE REACHED, IN AN EMERGENCY, DO NOT HESITATE TO MEDICATE OR TRANSPORT STUDENT/INDIVIDUAL TO NEAREST HOSPITAL EMERGENCY DEPARTMENT**.

Both I and the parent/guardian believe, the child has demonstrated the knowledge and skills to carry and self-administer their Epipen, including when to tell an adult when they have used it and when symptoms do not improve after using the Epipen.

_____ Yes _____ No

X_____ _____

Texas-Licensed Physician's (Medical Provider) Signature **PRINT Physician's (Medical Provider) Name**

(_____) _____ (_____) _____ _____/_____/20_____

Physician's Phone # **Physician's Fax #** **Date**

Parent/guardian signs if student, according to the medical provider, will carry and self-administer the Epipen.

X_____ (_____) _____ _____/_____/20_____

Parent/Guardian Signature/Firma de Padre/Tutor **Phone #/#Teléfono** **Date/Fecha**

***Note*:** Recommend extra Epipen kept in the nurse's clinic in the event the Epipen carried by the student is lost or stolen.

X_____ _____ _____/_____/20_____

Nurse Signature **Print name** **Date/Fecha**