Scurry-Rosser Independent School District

Allergy Action Plan

Student Name:________________________________**Grade:**_____________**ID Number:** _________________________

Allergic to: ____

Weight:____________**lbs**__________**Asthma:** ______**Yes (higher risk for a severe reaction)**________**No**

Extremely reactive to the following: ____

THEREFORE:

______ if checked, give epinephrine immediately for ANY symptoms if exposure to the allergen was likely.

______ if checked, give epinephrine immediately if the exposure to the allergen was definite, even if no symptoms are noted.

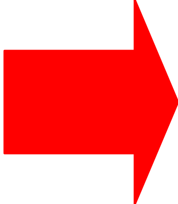
Any **SEVERE SYMPTOMS after suspected or known exposure:**

One or more of the following:

Lung: Short of breath, wheeze, repetitive cough
Heart: Pale, blue, faint, weak pulse, dizzy, confused
Throat: Tight, hoarse, trouble breathing/swallowing
Mouth: Obstructive swelling (tongue and/or lips)
Skin: Many hives over body

Or **combination** of symptoms from different body areas:

Skin: Hives, itchy rashes, swelling (e.g. eyes, lips)
Gut: Vomiting, diarrhea, cramping pain



1. **INJECT EPINEPHRINE IMMEDIATELY***
2. Call 911
3. Begin monitoring
4. Give additional medications**:
   a. Antihistamine
   b. Inhaler (bronchodilator) if asthma

*Note time given. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.

**Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parents
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

Medications/Doses:

Epinephrine (Brand and Dose): ____

Antihistamine (Brand and Dose): ____

Other (e.g. inhaler-bronchodilator if asthmatic): ____

Physician/Healthcare Provider Signature:______________________________________Date: __________

Physician Telephone Number: ____

Parent/Guardian Signature:____Date: __________

Parent/Guardian Telephone Number: ____

Scurry-Rosser Independent School District

Allergy Action Plan

Dear Parent/Legal Guardian:

The health and safety of your child is very important to us. On your child's health information sheet you indicated he/she has allergies. Please take the time to fill out the bottom of this form, and have your child's physician fill out the Allergy Action Plan on the back of this form.

Please return the form and any necessary emergency medication to the nurse's office as soon as possible.

Your child's teachers will be updated on their condition and will allow them to come to the nurse's office for evaluation/treatment when needed.

If you have any questions or concerns please feel free to contact your campus nurse.

Student's Name:________________________ Grade: _____ ID #: __________________

I hereby give permission to the school nurse, or school personnel designated by the principal to administer medication to my child as prescribed in the Allergy Action Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature:________________________________Date:____________

Daytime Phone Number:____

Emergency Contact: ____

Phone Number: ____

Emergency Contact: ____

Phone Number:____

I hereby give permission to the school nurse or school personnel designated by the principal to administer medication to my child as prescribed in his/her