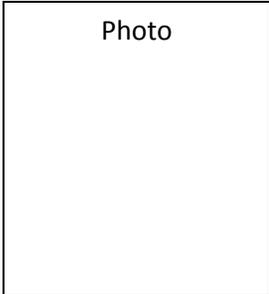


Severe Allergy Information and Medical Action Plan

Discovery Elementary School, Grades K-2
350 Highland Street, Williamston, MI 48895
Phone: (517) 655-2855 Fax: (517) 655-7504

Page one of this plan is to be completed, signed and dated by a parent/guardian. Page two of this plan is to be completed, signed and dated by the treating physician or licensed prescriber.



Photo

Name: _____ Date: _____

Date of Birth: _____ School: Discovery Elementary School

Age: _____ Grade: _____ Teacher: _____

Contact Information

Call First

Name: _____

Relationship: _____

Phone Number: _____

Alternate Number: _____

Call Second

Name: _____

Relationship: _____

Phone Number: _____

Alternate Number: _____

Allergy History and Information

1. List all allergic foods/substances: _____

2. Does your child have Asthma? (If yes, at a higher risk for severe allergic reaction) NO YES

3. List any other foods or substances to avoid? _____

4. Has your child ever been given an epinephrine shot for an allergic reaction? NO YES

5. Does your child need to sit at a nut free table in the cafeteria? NO YES

6. Should your child carry epinephrine to all locations throughout the school day? NO YES

If no, where would you like your child's epinephrine kept? Office Classroom Other _____

7. Is there any other information, restrictions or directions the school should be aware of? NO YES

Parent/guardian signature: _____ Date: _____

If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

If checked, give epinephrine immediately if the allergen was defiantly eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

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, crampy pain

1. **Inject Epinephrine Immediately**
 2. Call 911
 3. Call parent/guardian
 4. Begin monitoring (See “Monitoring” box below)
 5. Give additional medication* (If ordered)
- Antihistamine
-Inhaler

*Antihistamines & inhalers 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

NOSE: Itchy/runny nose, sneezing



1. **Give Antihistamine if ordered by physician**
2. Stay with student; Call parent/guardian
3. If symptoms progress: **USE EPINEPHRINE** (above)
4. Begin monitoring (See below)

Monitoring

Stay with student; call 911 and parent/guardian. Tell 911 that the child is having anaphylaxis and may need epinephrine when they arrive. Consider giving additional medication following epinephrine such as antihistamine or inhaler if wheezing. Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side. If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes after the last dose.

Authorized Physician/Licensed Prescriber Orders

Epinephrine dose .15 (junior) .3 (adult) **Epinephrine brand:** _____

Antihistamine name (if applicable) _____ **Dosage** _____

Other (e.g., Inhaler-bronchodilator if asthmatic): _____

Other instructions or orders: _____

Physician/licensed prescriber name (Please print) _____

Physician’s signature _____ **Date** _____