



SEVERE ALLERGY EMERGENCY ACTION PLAN

Name: _____ DOB: _____
 Student ID: _____ School: _____ Grade: _____
 Parent/Guardian: _____ Phone: _____
 Other contact: _____ Phone: _____

**PLACE
 PICTURE
 HERE**

HEALTHCARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:

Weight: _____ lbs. Asthma: Yes (higher risk for severe reaction) No
 Extremely reactive to the following allergens: _____
 Antihistamine Brand or Generic: _____ Dose: _____
 Epinephrine Brand or Generic: _____ Dose: 0.1mg IM 0.15mg IM 0.3mg IM
 If checked, give epinephrine immediately if exposed to allergen, even if NO symptoms are apparent.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

MILD SYMPTOMS



NOSE

Itchy or
 runny nose,
 sneezing



MOUTH

Itchy mouth



SKIN

A few hives,
 mild itch



GUT

Mild
 nausea or
 discomfort

For **MILD** symptoms from a single system area:

1. If ordered, give antihistamine
2. Stay with the student and alert emergency contact
3. Watch closely for changes. If symptoms worsen give epinephrine.

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA

GIVE EPINEPHRINE

SEVERE SYMPTOMS



LUNG

Shortness of
 breath, wheezing,
 repetitive cough



HEART

Pale or bluish
 skin, faintness,
 weak pulse,
 dizziness



THROAT

Tight or hoarse
 throat, trouble
 breathing or
 swallowing



MOUTH

Significant
 swelling of the
 tongue or lips



SKIN

Many hives over
 body, widespread
 redness



GUT

Repetitive
 vomiting, severe
 diarrhea



OTHER

Feeling
 something bad is
 about to happen,
 anxiety, confusion

**OR A
 COMBINATION**
 of symptoms
 from different
 body areas.

FOR ANY SEVERE SYMPTOM(S):

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. **CALL 911**, tell dispatcher epinephrine was administered
3. Lay student flat, raise legs and keep warm. If vomiting or difficulty breathing occurs let them sit up or lie on their side. Remain with student and provide comfort.
4. If symptoms do not improve, or symptoms return, a second dose of Epinephrine can be given 5-15 minutes after the last dose
5. Alert emergency contact
6. Student should be transported to the ER, even if symptoms resolve

Healthcare Provider Signature: _____ Date: _____

Print Provider Name: _____ Phone: _____

I approve this emergency action plan and give permission for this plan to be shared with school personnel that will be in contact with my student. I also give permission for the school nurse to contact the healthcare provider listed on this plan as needed in the care of my student.

Parent/Guardian Signature: _____ Date: _____