GREAT HEARTS ACADEMY – ALLERGY ACTION PLAN for the 2016-2017 School Year

CHILD **LAST** NAME: _____
FIRST NAME: _____ DOB:_____
PARENT/GUARDIAN: _____
BEST CONTACT PHONE NUMBER: _____
PHYSICIAN NAME: _____
PHYSICIAN PHONE NUMBER: _____
TEACHER: _____ SECTION _____

ALLERGIES: _____
TYPE OF REACTION: ____ Anaphylaxis____Nausea/Vomiting____Rash
Other reaction: _____
Allergic reaction may occur by: ____ Ingestion _____ Inhalation ____ Touch or Other: _____
Is the student asthmatic? _____ yes _____ no
My student will be eating food provided by local vendors for lunch _____ yes _____ no

☐ My child may exhibit **MILD** symptoms with exposure to allergen _____
Treatment of **MILD** symptoms include:

1. Note time and occurrence of symptoms and stay with student
2. Watch closely for any sign of a serious reaction
3. Call parent/guardian listed above or communicate in writing of event
4. Give the following Medication: _____ Given to nurse ____yes ____ date
   Dose: _____
   May repeat: _____
   Other instructions: _____
5. Call 911 or give emergency medications if symptoms worsen

☐ My child may exhibit **SEVERE** symptoms with exposure to allergen _____
(Exhibiting <u>any</u> or all of the following symptoms is considered to be a severe allergic reaction: widespread hives and flushing, widespread tissue swelling, swelling of the tongue, throat itching or a sense of tightness in the throat, hoarseness and/or hacking cough, vomiting, nausea, cramps, diarrhea, repetitive coughing, wheezing, trouble breathing, rapid heart rate, lightheadedness, dizziness, loss of consciousness) Treatment of **SEVERE** symptoms include:

1. Note time and occurrence of symptoms and stay with student
2. Call 9-1-1 and inform them of a severe allergic reaction
3. Administer according to package instructions(circle) EpiPen 0.3 mg intramuscularly Given to nurse ___yes
   EpiPen Jr. 0.15 mg intramuscularly
   Auvi-Q 0.3 mg intramuscularly
   Auvi-Q 0.15 mg intramuscularly
4. Call parent/guardian listed above, continue monitoring student for return of severe symptoms
5. Give injection device used, packaging, and student information to emergency responders
6. Give the following ANTIHISTAMINE: _____ Given to nurse ____yes ____ date
   Dose: _____
   May repeat: _____
   Other instructions: _____

I understand that school staff MUST be informed of my child's health concerns in order to provide safe and appropriate care. I will update the school nurse office as my child's health conditions/treatments change throughout the year.

Parent/Guardian signature: _____ Date: _____