

**ALLERGY EMERGENCY HEALTH CARE PLAN**  
**FOR STUDENTS AT HIGH RISK FOR SEVERE ALLERGIC REACTION**

**STUDENT'S NAME** \_\_\_\_\_ **ID#** \_\_\_\_\_

**ALLERGY TO:** \_\_\_\_\_

**SPECIAL CONSIDERATIONS:** \_\_\_\_\_

**SIGNS OF AN ALLERGIC REACTION MAY INCLUDE: PLEASE CIRCLE THOSE COMMON FOR YOUR CHILD.**

**SYMPTOMS:**

MOUTH     ITCHING AND SWELLING OF THE LIPS, TONGUE OR MOUTH  
THROAT    ITCHING AND/OR A SENSE OF TIGHTNESS IN THE THROAT, HOARSENESS, AND HACKING COUGH  
SKIN       HIVES, ITCH RASH AND/OR SWELLING ABOUT THE FACE OR EXTREMITIES  
GI TRACT   NAUSEA, ABDOMINAL CRAMPS, VOMITING AND/OR DIARRHEA  
LUNGS     SHORTNESS OF BREATH, REPETITIVE COUGHING AND/OR WHEEZING  
HEART      'THREADY' PULSE, 'PASSING OUT'  
OTHER      \_\_\_\_\_

THE SEVERITY OF THE ABOVE SYMPTOMS CAN CHANGE QUICKLY.

**ACTION:**

1. FOR SIGNS OF A SEVERE ALLERGIC REACTION, GIVE:

\_\_\_\_\_ (MEDICATION/DOSE/ROUTE)

2. CALL 9-1-1 IF EPIPEN IS GIVEN

3. CALL PARENT/GUARDIAN \_\_\_\_\_ PHONE \_\_\_\_\_

I CONSENT TO HAVE THE SCHOOL NURSE OR SCHOOL PERSONNEL DESIGNATED BY THE SCHOOL NURSE ADMINISTER THE MEDICATION PRECRIBED BY MY DOCTOR

I PLAN TO KEEP AN UPDATED EPIPEN WITH MY STUDENT AT ALL TIMES  
\_\_\_\_\_ YES \_\_\_\_\_ NO

I GIVE MY PERMISSION TO THE SCHOOL NURSE TO SHARE INFORMATION RELEVANT TO THE PRESCRIBED MEDICATION ADMINISTRATION AS HE/SHE DETERMINES APPROPRIATE FOR MY SON'S/DAUGHTER'S HEALTH AND SAFETY.

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PHYSICIAN PHONE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

RELATIONSHIP TO STUDENT:  
\_\_\_\_\_

EMERGENCY PHONE NUMBERS: \_\_\_\_\_