

GREAT HEARTS ACADEMY – ALLERGY ACTION PLAN for the 2018-2019 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 any 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: _____