



Student _____	Grade _____
DOB ___/___/___	School _____
Teacher/Homeroom _____	School Yr _____

SEVERE ALLERGY EMERGENCY HEALTH PLAN

ALLERGY TO: _____

Asthmatic Yes* ___ No ___ *Students with asthma are at risk for more severe reaction.

► SIGNS OF AN ALLERGIC REACTION ◀

Systems:	Symptoms:
•MOUTH	itching & swelling of the lips, tongue, or mouth
•THROAT*	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
•SKIN	hives, itchy rash, and/or swelling about the face or extremities
•GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
•LUNG*	shortness of breath, repetitive coughing, and/or wheezing
•HEART*	“thready” pulse, “passing-out”

The severity of symptoms can quickly change.
 *All symptoms can potentially progress to a life-threatening situation.

► ACTION FOR MINOR REACTION ◀

- If the **only symptom(s)** are _____,
 Give _____
 medication/dose/route/frequency
 Then:
- Call parents/guardians or emergency contacts.
- If symptoms do not improve in 10 minutes, follow steps for MAJOR REACTION below.

► ACTION FOR MAJOR REACTION ◀

- If **symptom(s)** are: _____,
 Give **EPI PEN** _____ **IMMEDIATELY!**
 dose/route
 Location of Epi Pen/s: Student _____ Health office _____ Cafeteria _____ *check all that apply*
 Then call:
- Rescue 911(ask for advanced life support).
- Parent/guardian or emergency contacts.
- Stay with student until paramedics arrive.

DO NOT HESITATE TO CALL FOR EMERGENCY HELP!

CONTACTS:

Parent/Guardian: _____ Home# _____ Work# _____ Cell/Pgr# _____

Parent/Guardian: _____ Home# _____ Work# _____ Cell/ger# _____

Physician/Clinic: _____ Phone# _____

Hospital of choice: _____

***I give Health Service Personnel permission to consult with the above named student's physician regarding any questions that arise about the medical condition and/or medications/treatments/procedures being used to treat the condition.**

Parent/Guardian signature _____ Date _____

Physician signature _____ Date _____

- We ask you to complete this form at the beginning of every school year to ensure that we have the most current information on your child.
- The school district intends to use the requested information to provide for your child's health and safety while at school.
- You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health plan for your child.
- The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety.
- If we are unable to reach you or your designee during an emergency, we will call 911 for assistance if needed.
- Please contact your school promptly with any changes of information on this form.

EIPEN® AND EIPEN® JR. DIRECTIONS

1. Pull off gray safety cap

2. Place black tip on outer thigh (always apply to thigh) through clothes



Using a quick motion, press hard into thigh until AutoInjector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds. Take the used unit with to the emergency room.