Raymond School District ALLERGY Action Plan

2659 76th Street, Franksville, WI 53126 PHONE: 262-835-2929 FAX: 262-835-2087

Student:_____ Date of Birth _____/_____/_____

Grade: _____ Teacher: _____ School Year _____

Allergy to: _____ Asthma? ☐ Yes (higher risk for severe reaction) ☐ No

Phone	Emergency Contact	Relationship

_____ **Extremely reactive to the following:** _____ **THEREFORE:**

- ☐ **If checked, give epinephrine immediately for ANY symptoms if allergen was likely to have come in contact with or ingested by student.**
- ☐ **If checked, give epinephrine immediately if allergen was definitely contacted, even if no symptoms are noted.**

_____ **Any SEVERE SYMPTOMS after suspected or known contact with allergen (one or more of the following):**

Lung: shortness of breath, wheeze, repetitive cough

Heart: pale, blue, faint, weak pulse, dizzy, confused

Throat: tight, hoarse, trouble breathing/swallowing

Skin: hives over body, swelling

Gut: vomiting, diarrhea, crampy pain

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1. **Inject epinephrine immediately.**
2. **Call 911 & parent.**
3. **Begin monitoring (see below).**
4. **Give additional medications:**

_____

_____

_____

_____

_____ **MILD SYMPTOMS ONLY:**

Mouth: Itchy mouth

Skin: A few hives around mouth/face, mild itch

Gut: Mild nausea/discomfort

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1. **Give antihistamine:** _____
2. **Stay with student, alert parent.**
3. **If symptoms progress (see above), USE EPINEPHRINE.**
4. **Begin monitoring (see below).**

MEDICATION

Epinephrine (brand and dose) _____ **location:**_____

Antihistamine (brand and dose) _____

Other (i.e.: inhaler-bronchodilator if asthmatic) _____

MONITORING

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back of this form for auto injection technique.

I have reviewed and approved this plan. I understand that designated school district personnel under the training and supervision provided by the school nurse will perform specialized health care services. I agree to hold the Raymond school district, and employee(s) who is (are) administering this plan harmless in any or all claims arising from the administration of this plan at school. I agree to be contacted with regard to this plan. This consent remains in effect to the end of the school year unless it is discontinued or changed in writing.

Parent Signature_____ Date _____

Physician signature_____ Date _____