Food/Other Allergic Reaction Emergency Action Plan

Student *Date of Birth*	Parent/Guardian
Today's Date	Home Phone
School	Work
Grade Teacher	Cell

Child is allergic to _____ *Will your child need medication regardless of symptoms? __Yes __No*

LOCATION OF EPI-PEN _____ Does your child have asthma? • No • Yes, at more risk for severe reaction

IF YOU SEE THIS	DO THIS
Itching, tingling, or swelling of lips, tongue, mouth Nausea, abdominal cramps, vomiting, diarrhea Hives, itchy rash, swelling of face or extremities	Give medication _____ Calm student Place in cool, quiet place Do not leave student alone Call Parent/Guardian
Tightening of throat, hoarseness, hacking cough Shortness of breath, coughing, wheezing	Give medication _____ Place student in <u>semi-upright position</u> Call 911- **do not leave student alone** Call Parent/Guardian
Weak pulse, fainting, pale or bluish color	Give medication_____ <u>Place on back - raise feet and legs</u> Call 911- **do not leave student alone** Call Parent/Guardian

What is the most usual sign/symptom of trouble for your child? __local swelling __hives
__trouble breathing __full faint, collapse "anaphylaxis"
__other _____

What usually helps _____

Parent/Guardian Signature_____ Date _____

Nurse Signature/Date_____

File original in Individual Health Record
Copies to appropriate staff and Emergency Action Notebook

Adapted NRMPS; rev. 2016

Food/Other Allergic Reaction Emergency Action Plan

This Allergy Action Plan/medication permission form for current school year must be on file for school staff to assist

Nurse Signature/Date_____

File original in Individual Health Record
Copies to appropriate staff and Emergency Action Notebook