School Year __/__

Student Photo

Slippery Rock School District
Allergy/Anaphylaxis Action Plan
Must be completed each school year

Student Name:_____ DOB_____Grade____ Room#_____

Confirmed Allergy:

- FOODS (List):_____
- STINGING INSECTS:_____
- LATEX (circle): Type 1 (anaphylaxis) –Type 2 (contact dermatitis)
  - HISTORY OF ASHTMA? (circle) Yes (high risk for severe reaction) No

Procedure to Follow:

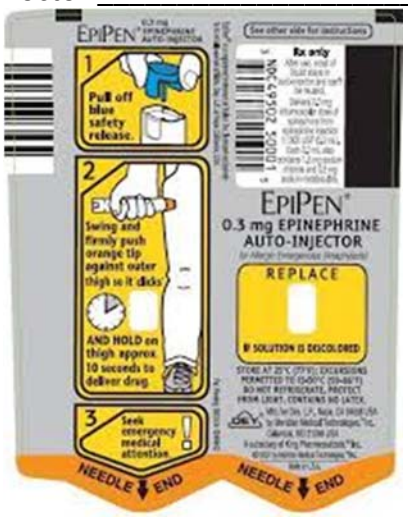
Assess symptoms following contact with allergen:

To be determined by physician authorizing treatment			**Give Checked Medications**
		Epinephrine	**Antihistamine**
No symptoms noted, observe for 15 minutes			
Mouth	Itching, tingling or oral swelling (lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of face or extremities		
Stomach/Gut	Nausea, abdominal cramps, vomiting or diarrhea		
Throat *	Tightening of throat, hoarseness, hacking cough		
Lung*	Shortness of breath, repetitive coughing, wheezing		
Heart*	Thready pulse, low Blood Pressure, fainting, pallor, cyanosis		
Neuro*	Disorientation, dizziness, or loss of consciousness		

Only a few symptoms may be present. Severity of symptoms can change quickly
***Potentially life threatening**

Treatment:
Epinephrine: (medication name/dose/route)_____
Antihistamine: (medication name/dose/route)_____
Other: (medication name/dose/route)_____

Plan prepared by:
Doctor:_____ Signature:_____Date:_____



Action Plan:
1. Lay person flat. Do not allow them to stand or walk, If breathing is difficult allow to sit up
2. Give Epi Pen
3. Call 911
4. Phone family: _____, _____
5. Further adrenaline doses may be given if no response after 5 minutes

I give my permission for the school nurse to use the information provided to share with Slippery Rock School District personnel and for the nurse to contact my child's physician listed above to discuss my child's condition as needed.
Parent's Signature_____Date:_____