THE PRAIRIE SCHOOL

EMERGENCY ALLERGY ACTION PLAN

Health Office Fax: 262-752-2661

Student Name _____ D.O. B. ____/____/_____ Grade _____

Allerygy to: _____

Weight: _____ lbs. Asthma: ❑ Yes (higher risk for a severe reaction) ❑ No

Extremely reactive to the following foods: _____

THEREFORE:

❑ If checked, give epinephrine immediately for ANY symptoms if the allergen was ***likely*** eaten.

❑ If checked, give epinephrine immediately if the allergen was ***definitely*** eaten, even if no symptoms are noted.

Any **SEVERE SYMPTOMS** after suspected or known ingestion:

One of more of the following:

LUNGS:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing / swallowing
MOUTH:	Obstructive swelling (tongue and / or lips)
SKIN:	Many hives over body

OR

Combination of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring
4. Give additional medications:*
   - Antihistamine
   - Inhaler (bronchodilator) if Asthma

   * Antihistamines and inhalers / bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS only:

One of more of the following:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth / face, mild itch
GUT:	Mild nausea / discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress, see above. **USE EPINEPHRINE.**
4. Begin monitoring.

Medications / Doses:

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilators if asthmatic): _____

LICENSED PRESCRIBER: My signature indicates that I am in agreement with this plan and have authorized the medication(s) written or checked above. This will remain in effect through the end of the current school year.

____ In my opinion, this student has been trained in the use of an Epinephrine Auto-Injector and is capable of carrying it. A second Auto-Injector should be provided to the school.

____ In my opinion, an Epinephrine Auto-Injector should **not** be carried by this student (not age/developmentally appropriate).

Licensed Prescriber's Printed Name: _____ Phone: _____

Licensed Prescriber's Signature: _____ Date: _____

PARENT / GUARDIAN: My signature indicates that I am in agreement with this plan and will provide the appropriate medications.

____ In my opinion, this student has been trained in the use of an Epinephrine Auto-Injector and is capable of carrying it. A second Auto-Injector should be provided to the school.

____ In my opinion, an Epinephrine Auto-Injector should **not** be carried by this student (not age/developmentally appropriate).

Parent / Guardian Signature: _____ Date: _____