GRAND PRAIRIE I.S.D. SEVERE ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

NAME: _____ D.O.B: _____

TEACHER: _____ GRADE: _____

ALLERGIC TO: _____

Asthma? NO YES (higher risk for a severe reaction)

Photo

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)
SKIN: Many hives over body or (combination) hives, itchy rashes, swelling
GUT: Vomiting, diarrhea, cramping, pain

INJECT EPINEPHRINE IMMEDIATELY
*****Call 911*****
- Begin monitoring (see below)
- Additional medications: - Antihistamine
  - Albuterol

When in doubt, use epinephrine. Symptoms can rapidly become more severe

** Do Not Rely on Antihistamines or Bronchodilators to treat an anaphylactic reaction- GIVE EPI-PEN!

MILD SYMPTOMS ONLY
Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

GIVE ANTIHISTAMINE
Stay with child, alert nurse and parent
IF SYMPTOMS PROGRESS (see above).INJECT Epi-Pen

MONITORING: Stay with the child. Tell EMT epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

Physician Orders

Medications (Brand and Dose):	Directions:
EPINEPHRINE:	
ANTIHISTAMINE:	
Other (e.g., inhaler):	

☐ Student ***MAY*** self-carry and self-administer epinephrine ☐ Student ***MAY NOT*** self-administer epinephrine

Give epinephrine for ***ANY*** symptoms if the allergen exposure has likely occurred YES NO

Give epinephrine ***BEFORE*** symptoms if the allergen exposure has definitely occurred YES NO

Physician Name (print) _____ **Phone:** _____

Licensed Provider Signature: _____ **Date:** _____

EMERGENCY CONTACTS:

Parent/Guardian: _____ Ph: ( ) _____

Name/Relationship: _____ Ph: ( ) _____

Name/Relationship: _____ Ph: ( ) _____

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Guardian Signature: _____ Date: _____