ALLERGY EMERGENCY PLAN Student Name: _____ Student ID: ____ DOB: ____ School Name: ____ School Year: ____ Parent Name: ____ Home: ____ Work: ____ Cell: ____ Describe Symptoms:______ Allergic to: *Yes (Children with asthma have a higher risk for severe reaction) No Asthmatic: DO NOT DEPEND ON ASTHMA INHALER AND/OR ANTIHISTAMINES TO TREAT ANAPHYLAXIS!!! provided to school by parents with required documentation. Localized rash or hives or redness Antihistamines and Epinephrine Auto-Injectors need to be Med: ______ by mouth Symptoms Minor (Name of Antihistamine, i.e. Benadryl, and dose) Nausea or single episode of vomiting GIVE 9 Abdominal pain WATCH CLOSELY FOR WORSENING SYMPTOMS OR Red, itchy rash around mouth or on face **GIVE EPINEPHRINE NOW** Itching of face with or without swelling Scattered hives over the body **Major Symptoms** Eczema "flare-up" Name of Injector: _____ Dose: ____ Hoarseness Stridor (Abnormal high pitched sound when Respiratory **AND IF POSSIBLE GIVE GIVE** breathing in) Difficulty breathing/shortness of breath Med: ______ Dose:_____ by mouth Repeated coughing/wheezing Chest tightness (Name of Antihistamine, i.e. Benadryl, and dose) Repeated vomiting ច Drooling or difficulty swallowing Weak, rapid pulse ***CALL 911*** Cardio-vascular Lightheadedness or feeling faint Loss of consciousness

OPTION 1 OR 2 NEEDS TO BE COMPLETED AND SIGNED BY A PHYSICIAN IF STUDENT IS TO CARRY AND/OR SELF-ADMINISTER EPINEPHRINE:	
1. I have instructed student in the proper use and dosage of his/her epinephrine auto-injector. It is my professional opinion that this student should be allowed to carry and self administer (medication name and dose).	
2. This student should be allowed to carry this epinephrine auto-injector while at school and on school bus. Student is not capable of administration of this medication (medication name and dose).	
Physician's Signature:	Date: