THE PRAIRIE SCHOOL

Please submit to the Health Office
P: 262-752-2660 • F: 262-752-2661
E: healthoffice@prairieschool.com

Emergency Allergy Plan

Student Name _____ Date of Birth_____/_____/_____ Grade ____

Student Address _____

Parent/Guardian Name _____ Parent/Guardian Phone _____

Parent/Guardian Signature _____

Allergy to _____ Weight _____

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

MILD SYMPTOMS

One of more of the following:

- Mouth: Itchy mouth
- Skin: A few hives around mouth / face, mild itch
- Gut: Mild nausea / discomfort

TREATMENT PLAN

1. **Give Antihistamine**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress, see above. **Use Epinephrine.**
4. Begin monitoring.

SEVERE SYMPTOMS

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

TREATMENT PLAN

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).*
5. **Use Epinephrine**

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Emergency Allergy Plan

MEDICATION / 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 Printed Name: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____