CATOOSA COUNTY PUBLIC SCHOOLS
ALLERGY REACTION EMERGENCY ACTION PLAN

Place Child's Picture Here

School_____ **School Year** _____ **Date** _____

ALLERGY TO: _____

Student's Name: _____ **D.O.B.:** _____ **Teacher:** _____

Asthmatic: **Yes*** ☐ **No** ☐ **Higher risk for severe reaction** **Yes*** ☐ **No** ☐

I understand that it is my responsibility as the parent/guardian of_____**to notify the school nurse/designee of any changes in my child's health condition and/or medication/treatment regimen. I authorize my child's healthcare provider and his/her staff to release the following information regarding my child's health condition. I understand that this health information will ONLY be shared with pertinent school staff.**

_____

Parent/Guardian Signature **Date**

★ **SIGNS OF AN ALLERGIC REACTION** ★

(Check Student's Usual Symptoms):

	Systems:	**Symptoms:**
☐	***MOUTH**	**itching & swelling of the lips, tongue or mouth**
☐	***THROAT***	**itching and/or a sense of tightness in the throat, hoarseness and hacking cough**
☐	***SKIN**	**hives, itchy rash and/or swelling about the face or extremities**
☐	***GI Tract**	**(uncommonly) nausea, abdominal cramps, vomiting and/or diarrhea shortness of**
☐	***LUNG***	**breath, repetitive coughing and/or wheezing**
☐	***HEART***	**weak and "thready" pulse, loss of consciousness (passing out)**

The severity of symptoms can quickly change. *ALL above symptoms can potentially progress to a life-threatening situation.

★ ACTION ★

1. **If INGESTION, EXPOSURE, OR STING IS SUSPECTED, give**_____
   (medication, dose route)
   AND _____**IMMEDIATELY!**
   (other actions to be taken)
2. **Call 911 or local Emergency Medical Services.**
3. **Call: Mother/Guardian: ph#** _____ **Father/Guardian: ph#** _____
   cell# _____ **cell#** _____
   Other Emergency Contacts_____
4. **Or call Health Care Provider** _____**at**_____

DO NOT HESITATE TO CALL 911 EMERGENCY!!

FOR EMERGENCY MEDICATION: (EpiPen®Jr or EpiPen®)

☐ **I have instructed_____in the proper way to use his/her medication. It is my professional opinion that _____should be allowed to carry and use the medication by his/herself.**

☐ **It is my professional opinion that _____should NOT carry his/her medication by his/herself.**

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Healthcare Provider's Signature **Date**

Staff members trained to give EpiPen®Jr. or EpiPen® (name and room number)

1._____**2.**_____

3._____**4.**_____