Desoto Independent School District
Health Services 2019-2020
Allergy Action Plan

Student Name:_____ **DOB:** _____ **Grade:** _____

Allergies: _____

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

Extremely reactive to the following: _____

THEREFORE:

_____ if checked, give epinephrine immediately for ANY symptoms if exposure to the allergen was likely.

_____ if checked, give epinephrine immediately if the exposure to the allergen was definite, even if no symptoms are noted.

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

One or more of the following:

- **Lung:** Short of breath, wheeze, repetitive cough
- **Heart:** Pale, blue, faint, weak pulse, dizzy, confused
- **Throat:** Tight, hoarse, trouble breathing, difficulty swallowing
- **Mouth:** Obstructive swelling (of lips or tongue)
- **Skin:** Many hives over body

Or **combination** of symptoms from different body areas:

- **Skin:** Hives, itchy rashes, swelling (eyes, lips)
- **Gut:** Vomiting, diarrhea, cramping pain

1. INJECT EPINEPHRINE IMMEDIATELY*

2. Call 911
3. Begin monitoring
4. Give additional medications**
   a. Antihistamine
   b. Inhaler (bronchodilator) if asthma

*Note time given. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.
Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

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

Epinephrine (Brand and Dose): _____

_____

4. Continue monitoring

Antihistamine (Brand and Dose): _____

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

_____ (Initial if applicable) I have instructed the student in the proper way to use their emergency epinephrine. It is my professional opinion that they should be allowed to carry and/or self-administer the medication while on school property or at school related events.

_____ (Initial if applicable) Student does not need to carry emergency epinephrine, but it should be available in the office.

Physician/Healthcare Provider Signature:_____ Date: _____

Physician Printed Name and Telephone Number: _____

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Dear Parent/Legal Guardian:

The health and safety of your child is very important to us. On your child's health information sheet you indicated they have allergies. Please take the time to fill out the bottom of this form, and have your child's physician or other healthcare provider fill out the Allergy Action Plan on the back of this form.

Please return these forms and any necessary emergency medication (i.e. Benadryl, epinephrine) to the nurse's office as soon as possible.

Your child's teachers will be updated on their condition and will allow them to come to the nurse's office for evaluation and/or treatment when needed.

If you have any questions or concerns, please feel free to contact your campus nurse.

Student's Name:_____ **Grade:** ____ **ID #:** _____

I hereby give permission to the school nurse or school personnel designated by the principal to administer medication to my child as prescribed in the Allergy Action Plan. Alternatively, I give permission for my child to carry and self-administer prescribed emergency medication if cleared by their healthcare provider as noted in the Allergy Action Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition to this, I understand that this information will be shared with school staff as deemed appropriate for my child's health and safety. I understand that this permission is valid for the duration of the school year unless the nurse is informed by my child's provider or myself that it has been discontinued and I understand that changes to medication require a new action plan to be completed.

Parent/Guardian Signature:_____**Date:**_____

Printed Name: _____

Daytime Phone Number: _____

Emergency Contact: _____

Phone Number: _____

Emergency Contact: _____

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Phone Number:_____