Stephen – Argyle Central

Emergency Action Plan for Allergic Reactions

School Year: ___________________________________

ALLERGIES (medication, environmental and/or food): ____

Student Name:	Grade:
Parent(s)/Guardian:	
Address:	
Phone # (please specify)	

Accidental ingestion or exposure to the above allergen(s) could lead to a severe allergic reaction or anaphylaxis. Signs of an allergic reaction include:

- **Mouth – itching and/or swelling of lips, tongue or mouth**
- **Throat – itching and/or a sense of tightness in the throat, hoarseness or cough**
- **Skin – hives, itching and/or swelling of the face or extremities**
- **Stomach – nausea, abdominal cramps, vomiting and/or diarrhea**
- **Lungs – shortness of breath, repetitive cough and/or wheezing**
- **Heart – lightheadedness, fainting**

MUST BE COMPLETED BY PERSCRIBING PROVIDER

Treatment Plan:

1) If an accidental exposure is suspected or mild symptoms of reaction develop, give **Benadryl (diphenhydramine)** ____________ **mg** by mouth immediately (__________ teaspoons).
2) If hoarseness, a sensation of tightness in the throat, difficulty breathing, or any symptoms from two or more of the above symptoms develop, give **( ) Epi Pen 0.3 mg or ( ) Epi Pen Jr. 0.15 mg** and call **911** to arrange transport to the nearest medical facility.
3) Other treatment:

Signature of Provider: ____ **Date:** ______________

I request and give my permission for school personnel to administer the above medication to my child. I understand it is my responsibility to refill medication when notified, and that any changes in dosage or new medications require a new provider's signature. Discontinuations require a note from a parent. I understand the school is not liable for any adverse reactions.

Signature of Parent/Guardian: ______________________________________ **Date:** ____________

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE

Reviewed/Date ________________