

**MECKLENBURG COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH**

Emergency Action Plan and Order: Severe Allergy in School

Student's Name: _____ DOB: _____
 Student's Address: _____
 Student's Phone #: _____ Student's I.D.: _____
 Mother's Name: _____ Phone: Work _____ Cell _____
 Father's Name: _____ Phone: Work _____ Cell _____
 Preferred Hospital: _____
 School: _____ Teacher/Grade/Homeroom: _____
 School Year: _____ History of asthma: Yes No

Student is known to be highly allergic to: _____

Student's health care provider to complete the following information:

If ingestion of or contact with allergen is suspected; and/or if any of the following symptoms occur:

- tingling/itching/swelling of the lips, tongue, mouth, throat
- sense of tightness in the throat
- hoarseness, hacking cough
- repetitive coughing
- hives/itchy rash
- swelling around the face or extremities
- nausea, abdominal cramps, vomiting, diarrhea
- shortness of breath
- blue color/paleness to lips or nails
- wheezing
- "passing out"
- low blood pressure

Give medications immediately

- a. Benadryl _____ mg by mouth (**Indicate dosage**)
 b. EpiPen 0.3 mg IM OR EpiPen Jr. 0.15mg IM (**Check one**)

If Epinephrine is given, call 911 immediately.

- Monitor vital signs.
- Call parent/notify school nurse/principal.

Other instructions:

Health Care Provider _____ **Phone #** _____ **FAX #** _____

Address: _____

Health Care Provider's signature: _____ **Date:** _____

(Please sign here to authorize this order and return to the School Health Program, MCHD, Hal Marshal Annex, 618 North College Street, Charlotte, N.C. 28202 Fax: 704-432-2079 Attn: School Health.)

Parent /Guardian Signature _____ **Date** _____

School Health Nurse Signature _____ **Date** _____