**Mecklenburg County Health Department**
**School Health Program**

**SEVERE ALLERGIC REACTION EMERGENCY ACTION PLAN** Name: _____

School: _____Year: _____Grade: _____ Date of Birth: _____

Homeroom Teacher: _____ Room: _____Student ID #: _____

Parent/Guardian: _____ Ph. (H) _____

Address: _____ Ph. (W) _____

Parent/Guardian: _____ Ph. (H) _____

Address: _____ Ph. (W) _____

Emergency Phone Contact #1 _____ _____ _____
Name Relationship Phone

Emergency Phone Contact #2 _____ _____ _____
Name Relationship Phone

Physician treating student: _____ Ph.: _____

Other Physician: _____ Ph.: _____

Preferred Hospital: _____

## EMERGENCY PLAN

(Fill in blanks, cross out any steps not needed for this student.)

**Child is known to be highly allergic to:** _____

1. **Possible signs of severe allergic reaction:**
   - *Sudden onset
   - *Flushed skin, possible hives
   - *Loss of consciousness, shock, coma
   - *Tingling sensation around mouth or face, nasal congestion
   - *Swelling of the throat, hoarseness
   - *Difficulty breathing, wheezing
   - *Puffy face, mouth, or eyelids or generalized swelling
   - *Low blood pressure with weak, rapid pulse
   - *Feeling of apprehension, sweating, weakness, generalized itching; esp. of palms of hands or throat/mouth
   - *Other: _____
2. **Steps to take during a severe allergic reaction:**
   - Immediate injection of Epi-pen if student has written order, otherwise immediately call 911
   - If child has been stung by insect attempt to remove stinger as soon as possible by gently scraping stinger out of skin using fingernail or piece of cardboard. **Do not** pinch or use tweezers as this will inject more venom. Apply ice pack.
   - **Call 911 if not already done.** Transport to _____ Hospital.
   - Call parent/guardian or physician
   - Notify principal
   - Monitor blood pressure and respirations if possible
   - Elevate legs if blood pressure is low
   - Cover with blankets if necessary to keep student warm
   - Other care for this student: _____
3. **Steps to prevent allergic reactions:** _____
   _____

*** PLEASE NOTE: If medications are to be taken at school, a Medication Authorization form must be completed by the parent and physician and kept at the school.**

This information will be shared with appropriate school staff unless you state otherwise.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____