

Dudley-Charlton Regional School District
Emergency Health Care Plan
Allergy Action Response

Name: _____ Grade: _____

What Allergy does the child have: _____

Is this child at high risk for Severe Reaction? Yes _____ No _____

Has this child ever used an Epi-Pen for Reaction? Yes _____ No _____

Has this child ever been hospitalized for an allergy? Yes _____ No _____

Is this child asthmatic? Yes _____ No _____

Please indicate symptoms child develops:

_____ Itching and swelling of the lips, tongue or mouth

_____ Itching and/or a sense of tightness in the throat, hoarseness and hacking cough

_____ Hives, itchy rash and/or swelling about the face or extremities

_____ Nausea, abdominal cramps, vomiting and/or diarrhea

_____ Shortness of breath, repetitive coughing and/or wheezing

_____ "Thready" pulse, "passing out"

ALL ABOVE SYMPTOMS CAN POTENTIALLY PROGRESS TO A LIFE-THREATENING SITUATION.

Action Plan

1. If child has been exposed to an allergen or ingestion is suspected with symptoms of:

_____ Give: _____ Immediately

2. Medications to be kept at school (in order to be give):

1. _____

2. _____

3. Call 911, notify EMS of allergic reaction and Epi-pen administration

4. Call Parent/Guardian: _____ at _____

5. Child must carry Epi-pen in fanny pack _____ Bus only _____ At all times _____ no needed

6. Child should be seated in the front seat of the bus. Yes _____ No _____

We must have a physician's signature if the child has medication to be given for allergic reactions at school.

Physician's Signature: _____ **Date:** _____

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