Desoto County Schools
Allergy Reaction Emergency Plan

Student:	Parent/Guardian:
Date of Birth:	Home Phone:
Grade: Teacher:	Work:
School:	Cell:

Student is allergic to _______________ *Will your child need medication regardless of symptoms? __Yes __No*

Location of Epi-Pen _______________ *Does your child have asthma? __No __Yes, at more risk for severe reaction*

If You See This…….	**Do This……..**
Itching, tingling, or swelling of lips, tongue, mouth Nausea, abdominal cramps, vomiting, diarrhea Hives, itchy rash, swelling of face or extremities	Give medication _______________ Calm student Place in cool, quiet place Do not leave student alone Call Parent/Guardian
Tightening of throat, hoarseness, hacking cough Shortness of breath, coughing, wheezing	Give medication _______________ Place student in semi-upright position Call 911- **do not leave student alone** Call Parent/Guardian
Weak pulse, fainting, pale or bluish color	Give medication _______________ Place on back—raise feet and legs Call 911- **do not leave student alone** Call Parent/Guardian

What is the most usual sign/symptom of trouble for your child? __local swelling __hives
__trouble breathing __full faint, collapse "anaphylaxis"
__other _______________

What usually helps _______________

This is the medication form if signed by Healthcare Provider

Medications

Epinephrine ___Epi-Pen ___Epi-Pen Jr. ___Twinject 0.3mg __Twinject 0.15 mg

Antihistamine _______________ __tablet __liquid Amount_______________

Other medication: _______________

Parent/Guardian Signature _______________ Date_______________

Healthcare Provider Signature _______________ Date_______________

required