# Donegal School District
# Allergy Action Plan

Parents, you have indicated that your child currently has an allergy. So that we can better care for your child, please complete the following information and return this form to the school nurse immediately.

**Student information**

Name: _____ DOB: _____
Grade:_____ Homeroom Teacher_____
Allergies: _____
Asthma Yes *(high risk for severe reaction)* No
Additional health problems besides anaphylaxis: _____
_____
Concurrent medications: _____
_____

**Symptoms of Anaphylaxis**

MOUTH itching, swelling of lips and/or tongue
THROAT* itching, tightness/closure, hoarseness
SKIN itching, hives, redness, swelling
GUT vomiting, diarrhea, cramps
LUNG* shortness of breath, cough, wheeze
HEART* weak pulse, dizziness, passing out

*Only a few symptoms may be present. Severity of symptoms can change quickly.*
**Some symptoms can be life-threatening. ACT FAST!*

**Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!**

**1.** Inject epinephrine in thigh using (check one): □Epineprine (0.15 mg) □Epinephrine (0.3 mg)
Other medication/dose/route: _____
IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.
**2.** Call 911 or rescue squad (before calling contact)
**3.** Emergency contact #1: home_____ work_____ cell_____
Emergency contact #2: home_____ work_____ cell_____
Emergency contact #3: home_____ work_____ cell_____

**Self Administration/Consent to Carry:**

**Epinephrine Use: This student was taught how to administer his/her Epinephrine auto injector or anaphylactic kit and demonstrates the capability for self-administration and for responsible behavior in the use of his/her medication. He/she has permission to carry and self-administer his/her Epinephrine or anaphylactic kit as prescribed, when needed. *The student shall notify the nurse or designee immediately.* If the student abuses or ignores the school policies, the medication may be confiscated and the privilege to carry the medication may be removed.

_____ _____
**YES** **NO**

_____ _____ _____
**Physician's Signature** **Date** **Phone Number**

*Signing verifies that the above Emergency Action Plan has been prescribed by you, the child's physician and should be carried out by the school he/she attends.

_____ _____
**Parent's Signature** **Date**

**Signing verifies that you, the parent/guardian give permission for the school staff to carry out the administration of the above prescribed plan in your absence and relieve the Board and its employees of responsibility for the benefits or consequences for such medication and its administration.