

CONRAD WEISER AREA SCHOOL DISTRICT
LIFE THREATENING ALLERGY ACTION PLAN

STUDENT NAME _____ DOB _____ BCTC (Y/N) GRADE _____ Section _____

SEVERE ALLERGY TO _____ Asthma diagnosis? [] Yes [] No

PARENT/GUARDIAN: COMPLETE EMERGENCY CONTACT INFORMATION ON THE BACK OF THIS FORM.
Only the student's own Epinephrine auto injector can be taken on a field trip.
Antihistamines will not be administered by unlicensed personnel.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG

Short of breath, wheezing, repetitive cough



HEART

Pale, blue, faint, weak pulse, dizzy



THROAT

Tight, hoarse, trouble breathing/ swallowing



MOUTH

Significant swelling of the tongue and/or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.



1. INJECT EPINEPHRINE IMMEDIATELY.
2. Call 911. Tell them the child is having anaphylaxis and may need additional epinephrine when they arrive.
 - **NURSE ONLY:** Consider giving additional medications following epinephrine:
 - Antihistamine
 - Inhaler (bronchodilator) if wheezing
3. Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - **NURSE ONLY:** If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
4. Alert emergency contacts.
5. EMS to transport to preferred hospital for further evaluation.

MILD SYMPTOMS



NOSE

Itchy/runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea/ discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

*****NURSE ONLY*****

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, Epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [] 0.15 mg IM [] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

PHYSICIAN AUTHORIZATION SIGNATURE

DATE

Please complete and sign both sides of this form.

Student Name _____ DOB _____ Grade _____ Section/Teacher _____

AUTHORIZATION FOR PERMISSION TO CARRY EPINEPHRINE AUTO-INJECTOR

I give permission for this child to carry and self-administer the prescribed Epinephrine Auto-Injector during school and school activities. This student has physician permission to do so and has been instructed in the proper procedure for self-administration.

Physicians' Printed Name

Physician Signature

Date

Phone #

Parent's Printed Name

Parent's Signature

Date

STUDENT EMERGENCY CONTACT INFORMATION

Parent/Guardian Contact _____ Phone # _____

Parent/Guardian Contact _____ Phone # _____

Additional Emergency Contact _____ Phone # _____

Additional Emergency Contact _____ Phone # _____

Preferred Hospital _____ Physician _____ Phone # _____

ATTENTION PARENTS/GUARDIANS

- Please complete the Life Threatening Allergy Action Plan if your child is prescribed an Epinephrine Auto-injector for a severe allergy. The *PARENT or GUARIDAN* and *PHYSICIAN* are required to sign the form. Additional copies are available in the nurse's office and on the district website
- Epinephrine Auto-injectors must be delivered to the school nurse in the **ORIGINAL CONTAINER**, with the prescription label attached.
- This information is only used in regard to the administration of Epinephrine in an emergency, it needs to be completed **each school year**, and you are still **required** to complete the District Emergency Information Form **each year**.