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/orlips

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 bodyareas.

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**.