Allergy Action Plan

ALLERGIC TO:____

Name of Student: ______________________________ DOB: ____________ Grade/Teacher: ____________________

Asthmatic _____Yes* _____ No *High risk for severe reaction

Requires an inhaler at school and Asthma Action Plan completed as per NC State Law.

◆ SIGNS OF AN ALLERGIC REACTION ◆

Systems:	**Symptoms: (circle appropriate symptoms)**
-MOUTH	itching, tingling, and swelling of the lips, tongue, or mouth
-THROAT*	tightness of throat, hoarseness, and hacking cough
-SKIN	hives, itchy rash, and/or swelling about the face or extremities
-GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
-LUNG*	shortness of breath, repetitive coughing, wheezing
-HEART*	weak or thready pulse, low blood pressure, fainting, pale, blueness
-OTHER	____

The severity of symptoms can quickly change and potentially progress to a life-threatening situation.

◆ ACTION FOR MINOR REACTION ◆

If **symptom(s)** are mild: □ **Benadryl** ____
(dosage)

Other Medicine List: ____
(medication/dosage/route)

If condition does not improve within 10 minutes or worsens any time, follow steps for Major Reaction below.

◆ ACTION FOR MAJOR REACTION ◆

If ingestion is suspected and/or symptoms are major give the following **IMMEDIATELY!**

□ **Epinephrine (Epi-Pen) 0.15mg Jr** □ **Epinephrine (Epi-Pen) 0.3 mg**

CALL 911 AND THE PARENT/GUARDIAN.

□ **I have instructed this student in the proper way to use his/her Epi-pen. It is my professional opinion that he/she should be allowed to carry this medication and administer to himself/herself.**

Physician's Signature ___________________________________ **Date:** __________________
Print/Stamp physician name, address and phone number:

Allergy Action Plan (con't)

Name of Student: ___________________________________ DOB: ____________

School: ____ Grade/Teacher: ____________________

All medication for use at school will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

Parent Permission

□ **I give permission for my child to carry and self-administer his/her Epi-pen.**
*Parent/guardian must provide an extra Epi-pen to be kept at school in case of emergency.

□ **I DO NOT give permission for my child to carry and self-administer his/her Epi-pen.**

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release Neuse Charter School Board of Directors and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for one year, unless revoked.

I give permission to designated staff members of Neuse Charter School to perform and carry out the tasks as outlined by this Allergy Action Plan. I also consent to the release of the information contained in this Allergy Action Plan to all staff members and other adults who have custodial care of my child and who need to know this information in order to maintain my child's health and safety.

Acknowledged and received by:

Parent/Guardian ____ Date _____________________

Parent Email address __________________________________ Parent Phone Numbers _______________________

EMERGENCY CONTACTS: Name/Relation

1.______________________________a) home____________ b) work _____________ c) cell______________

2.______________________________a) home____________ b) work _____________ c) cell______________

3.______________________________a) home____________ b) work _____________ c) cell______________

Principal's Signature ____ Date ________________

School First Responder Signature ________________________________ Date ________________