PROVIDENCE ACADEMY **HEALTH SERVICES**

SEVERE ALLERGY RESPONSE PLAN

To be Completed by Parent:

Student Information:

Student Name: _____Age: _____ DOB: _____Grade: _____

Emergency Information:

Parent/Guardian Name(s): _____

	Phone Number	Cell	Work
Mother/Guardian			
Father/Guardian			

Emergency Phone Contact #1_____
Name Relationship Phone

Emergency Phone Contact #2_____
Name Relationship Phone

Physician Name: _____ Telephone: _____

Preferred Local Emergency Department: _____

CHECK ANY SEVERE ALLERGY(IES) YOUR CHILD HAS:

_____Insect Stings (List Type) _____
_____Food (List Type) _____
_____Animal (List Type) _____
_____Dust
_____Grass
_____Other (List) _____

CHECK SIGNS USUALLY PRESENT DURING AN ALLERGY ATTACK

_____Difficulty Breathing _____Difficulty in Swallowing
_____Loss of Consciousness _____Rash
_____Nausea _____Flushed or unusually pale skin
_____Swelling: How much? _____ Where? _____
_____Other (List) _____

Has hospitalization been needed in the past for allergies? _____ NO _____ YES (If YES) When? _____

Notify Parent/Guardian in the following situations: _____

I give permission for my child to administer, be administered or assisted in the self-administration of the Epi-Pen by authorized persons. This includes both in school and on field trips. The school nurse has my permission to share the information provided with appropriate members of the educational team on a "need to know" basis in a confidential manner. A parent/guardian signature includes permission for the nurse to communicate with the provider listed with any questions. The school, its employees and agents shall incur no liability as a result of injury sustained by the student or any other person from possession or self-administration of his/her medication. The school shall incur no liability and the parent/guardian shall indemnify and hold harmless the school and its employees against any claims relating to the possession or self-administration of the Epi-Pen.

_____ _____
Parent/Guardian Signature Date

PHYSICIAN ORDER FORM FOR AN ALLERGIC REACTION

To be Completed by Physician:

Student Name: _____ **DOB:** _____

ALLERGY(IES) TO: _____

Hx of Asthma: YES NO **High risk for severe reaction: YES NO**

Student requires an Epinephrine Auto Injector at school: YES NO **Self-carry Epinephrine: YES NO**

SIGNS OF AN ALLERGIC REACTION

Systems:	**Symptoms:**
MOUTH	itching & swelling of the lips, tongue, or mouth.
THROAT	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough.
SKIN	hives, itchy rash, and/or swelling about the face or extremities.
STOMACH	nausea, abdominal cramps, vomiting, and/or diarrhea.
LUNG	shortness of breath, repetitive coughing, and/or wheezing.
HEART	pale or bluish skin, dizzy, "thready" pulse, "passing-out"

ACTION FOR PREVENTION: Please list allergens to avoid: _____

ACTION FOR MINOR REACTION:

1. If symptom(s) is/are: _____, give_____
Medication/dose/route

Then call:
2. Mother/Guardian _____ Father/Guardian _____, or Emergency contacts.

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

ACTION FOR MAJOR REACTION:

If ingestion is suspected and/or symptom(s)_____

Give_____

Then call:
1. 911
2. Parents, Guardians, or Emergency Contacts.

_____ _____
Physician's Signature Date

_____ _____
Print Physician's Name Phone Number