PEQUOT LAKES PUBLIC SCHOOLS

Student_____ Grade_____

DOB___/___/___School_____

Teacher/Homeroom_____ School Year _____

SEVERE ALLERGY EMERGENCY HEALTH PLAN

ALLERGY TO: _____ ICD 10 Code(s)_____

➢Asthmatic Yes☐ No☐ *Students with asthma are at risk for more severe reactions.

Triggers: _____

Avoidance Techniques:_____

⇨ **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 of the face or extremities
GUT	Nausea, abdominal cramps, vomiting, and/or diarrhea
LUNG*	Shortness of breath, repetitive coughing, and/or wheezing
HEART*	"Thready" pulse, "passing-out"

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

⇨ACTION FOR **MINOR REACTION**

1. If only symptom(s) are_____
   a. Give: _____
      medication/dose/route then call:
2. Parent or guardian or emergency contact: _____
3. If symptoms do not improve in 10 minutes, follow steps for MAJOR REACTION below.

⇨ACTION FOR **MAJOR REACTION**

1. If symptom(s) are: _____
   Give **Epinephrine Auto Injector** IMMEDIATELY
   a. Location of Epinephrine: Classroom_____ Health office_____ Other_____
2. Then call:
   a. Rescue **911**, inform them that Epinephrine was administered
   b. Parent or guardian or emergency contact
3. Stay with student until paramedics arrive and give them used epinephrine injector
   DO NOT HESITATE TO CALL FOR EMERGENCY HELP!

FIELD TRIP PLAN:_____

Hospital of choice:_____

Parent or Guardian signature:_____ Date_____

- **I give health service personnel permission to consult with the above named student's health care provider regarding any questions that arise about the medical condition and/or medications/treatments ordered.**
- **If we are unable to reach you or your designee during an emergency, we will call 911 for assistance if needed.**
- **Please contact your school promptly with any changes of information on this form.**
- **It is recommended that the parent or guardian complete a transportation form from the bus company.**

Health care provider signature:_____ Date_____