Lubbock Christian School

Severe Allergy Action Plan &
Request for Anaphylaxis Medication

Student Name: _____ DOB: _____Grade: _____Year: _____
ALLERGIC TO: _____
Probable Symptoms: _____
ASTHMATIC? ____Yes____No **Higher risk for severe reaction

Common Signs and Symptoms of Severe Allergic Reaction	
Throat*	Tightening, hoarseness, hacking cough
Lungs*	Shortness of breath, repetitive cough, wheezing
Heart*	Thready pulse, low BP, fainting, pale, blue skin
Mouth	Itching, tingling, swelling of lips, tongue, mouth
Skin	Hives, itchy rash, swelling of face or extremities
Gut	Nausea, abdominal cramps, vomiting, diarrhea
***Potentially life threatening/severity can rapidly change**	

For suspected or confirmed exposure or ingestion of allergen, escort to nurse immediately and give medication as follows:

For Minor Reaction:

1. If symptoms are_____
   give_____
2. Notify parent/guardian (name and contact #)_____
3. If condition does not improve within 10 minutes, follow steps for severe reaction:

For Severe Reaction:

1. If symptoms are_____
   give EpiPen 0.3 mg EpiPen Jr. 0.15mg
   Other_____
   _____
2. Call 911 and state that an allergic reaction has been treated with epinephrine
3. Notify parent/guardian
4. Repeat epinephrine after _____ minutes if symptoms not improved
5. Stay with student and monitor breathing and circulation until EMS arrive

(Continued on next page)

EVEN IF PARENT CANNOT BE REACHED, DO NOT HESITATE TO INITIATE EMERGENCY PLAN AND CALL 911

Antihistamine for student is located_____

Epinephrine for student is located_____

Physician Authorization for Student to Carry and Self-Administer Emergency Medication

_____ It is my professional opinion that this student **SHOULD** be allowed to carry and self-administer epinephrine in the prescribed form and dosage while on school property or at school related events.

_____It is my professional opinion that this student **SHOULD NOT** be allowed to carry and self-administer epinephrine while on school property or at school related events.

Printed name of Physician_____ Date_____

Physician's Signature_____ **Office Phone**_____

I request that oral medication and epinephrine, which I have provided, be administered to my child according to the signed protocol from my child's physician. I hereby give my permission to the school nurse and/or trained school personnel to follow this plan and to consult with the prescribing physician regarding the above orders.

Parent/Guardian Signature_____**Date**_____

School Nurse Signature_____ **Date**_____