DOUGLAS COUNTY SCHOOLS ALLERGY ACTION PLAN

Form to be completed by medical provider

Name ___________________________ Date of Birth ___________________________
Address ___________________________ Emergency Contact/Phone ___________________________
Health Care Provider Name ___________________________ Phone ___________________________

Allergy to: ___________________________ Asthmatic: □ YES □ No  *Higher Risk Severe Reaction
Medications Prescribed: _______________________________________________________________

Any SEVERE SYMPTOMS after suspected or known ingestion or exposure:
One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips) SKIN: Many hives over body

Or combination of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, diarrhea, crampy pain

1. INJECT EPINEPHRINE IMMEDIATELY
   2. Call 911
   3. Begin monitoring (see box below)
   4. Give additional medications:* Antihistamine -Inhaler (bronchodilator) if asthma

   *Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:
MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

1. GIVE ANTIHISTAMINE
   2. Stay with student; alert healthcare professionals and parent
   3. If symptoms progress (see above), USE EPINEPHRINE
   4. Begin monitoring (see box below)

Monitoring
Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given, in the opposite leg, 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See attached for auto-injection technique.

Health Care Provider Signature ___________________________ Date ___________________________
Parent or Guardian Signature ___________________________ Date ___________________________