Springfield Public Schools

Allergy Action Care Plan

(2021-2022 School Year)

PICTURE

Student's Name:_____ DOB:_____ Grade/Teacher: _____

ALLERGY TO_____

Asthmatic? ( ) yes* ( ) no ***Higher risk for severe reaction**

Detailed history of allergic reaction::_____

_____

_____

Symptoms:		**Give Checked Medication****
		**To be determined by physician
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	__Epinephrine __Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	__Epinephrine __Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	__Epinephrine __Antihistamine
• Throat	Tightening , hoarseness, hacking cough	__Epinephrine __Antihistamine
• Lung	Shortness of breath, repetitive coughing, wheezing	__Epinephrine __Antihistamine
• Heart	Thready pulse, low blood pressure, fainting, pale, blueness	__Epinephrine __Antihistamine
• Other	_____	__Epinephrine __Antihistamine
• If reaction is progressing (several of the above areas affected) give		__Epinephrine __Antihistamine

Note: The severity of these symptoms can quickly change.

DOSAGE (to be completed by physician):

Epinephrine: ___EpiPen Jr. __EpiPen ____other_____ _____not necessary

Inject intramuscularly and hold in place for 3-10 seconds, based on manufacturer instructions, before removing

Antihistamine: give_____

Medication/dose/route/frequency

Other: give_____

Medication/dose/route/frequency

- **EMERGENCY CONTACT INFORMATION ***

CALL 911 if epinephrine has been given even if parent/guardian has not been reached and/or condition worsens.

Parent/guardian_____Home:_____Cell_____Work_____

Parent/guardian_____Home_____Cell_____Work_____

Additional contact_____

Name/relationship Home/work/cell phone numbers

Additional contact_____

Name/relationship Home/work/cell phone numbers

IF EMERGENCY SITUATION OCCURS, DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS CANNOT BE REACHED.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE SCHOOL NURSE'S SIGNATURE DATE

Physician's Signature_____Date_____

Physician's printed name_____Phone_____

Physician's address_____

Street City State Zip

Revised 02 24 2021