Asheboro City Schools **8/11**
Emergency Action Plan

Food and Insect Allergy Action Plan

Student's Name: _____ DOB: _____

School: _____ Teacher: _____ Grade: _____

ALLERGY TO: _____

Asthmatic: YES / NO **High risk for severe reaction? Yes / NO**

Signs of Allergic Reaction Include:

Systems:	Symptoms:
MOUTH	Itching and swelling of the lips, tongue or mouth
THROAT	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
LUNG	Shortness of breath, repetitive coughing, wheezing
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
STOMACH	Nausea, abdominal cramps, vomiting
HEART	"Thready" pulse, passing out

******The severity of symptoms can quickly change and can be life threatening!!!******

INTERVENTION BY SCHOOL STAFF

1. **STAY WITH STUDENT**
2. **DIRECT A STAFF MEMBER TO CALL 911 IF A LIFE THREATENING SITUATION IS DEVELOPING AND THEN CALL PARENTS.**
3. **CALL THE CRISIS TEAM**
4. **ADMINISTER MEDICATIONS AS FOLLOWS, AS INDICATED BY THE PHYSICIAN AUTHORIZATION FORM.**

MEDICATION LOCATION: _____

ANTIHISTAMINE: _____

EPINEPHRINE**:** Inject intramuscularly and record time of administration. Circle one: (See reverse side for administration instructions)

Epipen **Epipen Jr.** **Adrenaclick**

5. **If stung, remove stinger, apply cool compress to site and elevate. (DO NOT SQUEEZE STINGER)**
6. **Monitor breathing**
7. **If school nurse is not present, please make certain to notify her/him of the event.**

******DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 IF SEVERE REACTION******

Parent Signature: _____ Date: _____
(Your signature indicates that you are in agreement with this plan and we (school) will follow it in case of an emergency.)