COLUMBIA PUBLIC SCHOOLS
Health Services
EMERGENCY ACTION PLAN-ALLERGY & ANAPHYLAXIS

Name: **Student #:** **D.O.B:**

ALLERGY TO:

Asthmatic (circle one): Yes ** No ***Higher risk for severe reaction**

Parent/Guardian: (Home) (Work) (Cell)
Mother:
Father:

Other:

If These Symptoms:	**Then Give Checked Medication**:**
	** (To be determined by physician authorizing treatment)
• If allergen has been ingested (food, sting), but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
• Mouth: Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
• Skin: Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
• GI: Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
• Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
• Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
• Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
• Other _____	☐ Epinephrine ☐ Antihistamine
• If reaction is progressing (several above areas affected), give	☐ Epinephrine ☐ Antihistamine

If epinephrine is administered during a reaction, call 911. State an allergic reaction has been treated and additional epinephrine may be needed. Send used epinephrine injection device with student to Emergency Room.

Antihistamine to be given:

_____
Medication/dose/route

IN CASE OF SEVERE ALLERGIC REACTION:

Epinephrine: Inject intramuscularly (circle all that apply) EpiPen® EpiPen® Jr Auvi-Q® 0.15 mg Auvi-Q® 0.3 mg.
Please note: Columbia Public Schools has an EpiPen® on site at all schools.

Doctor's Signature_____ Date_____
(Required)

Parent Consent for Management of Allergic Reaction at School

I, the parent or guardian of the above named student, request that this emergency action plan be used to guide allergy care for my child. I agree to:

1. Provide necessary supplies and equipment.
2. Notify the school nurse of any changes in the student's health status.
3. Notify the school nurse and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school nurse to communicate with _____, the primary care provider/specialist about allergy as needed.
5. School staff interacting directly with my child may be informed about his/her special needs while at school.

Parent/Guardian Signature_____ Date_____

Reviewed by School Nurse:
Name:_____ Date:_____