



Dallastown Area School District

700 New School Lane
Dallastown, Pennsylvania 17313-9242
(717) 244-4021 Telephone

ALLERGY EMERGENCY ACTION PLAN

Student Name _____ Student ID _____ DOB _____ Grade _____ Teacher _____
Approximate Weight _____ Preferred Hospital _____

Known Allergies _____

Asthma [] Yes (high risk for severe reaction) [] No

Additional Health Problems _____

Concurrent Medications _____

EMERGENCY ACTION STEPS

Symptom	Give Checked Medication (to be determined by physician; see dosage below)	
• If allergen ingested, but <i>no symptoms</i>	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Mouth (itching, tingling, or swelling of lips, tongue, mouth)	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Skin (hives, itchy rash, swelling of the face or extremities)	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Gut (nausea, abdominal cramps, vomiting, diarrhea)	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Throat+ (tightening of throat, hoarseness, hacking cough)	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Lung+ (shortness of breath, repetitive coughing, wheezing)	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Heart+ (weak/thready pulse, low BP, fainting, pale, blueness)	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Other+ _____	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• If reaction is progressing (several of the above areas affected)	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

+ Potentially life-threatening. The severity of symptoms can quickly change.

DO NOT HESITATE TO GIVE EPINEPHRINE

DOSAGE

- EPINEPHRINE: Inject into thigh using _____ (medication/dosage)
 - If no improvement within 10 minutes, administer second epinephrine dose.
 - Student has permission to self-administer epinephrine and has been taught how/when to utilize appropriately.
[] YES [] NO (If YES, parent and student must complete self-administration form. See reverse side.)
- ANTIHISTAMINE: _____ (medication/dosage/route)
- OTHER: _____ (medication/dosage/route)

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

EMERGENCY CALLS

- Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
- Parent/Guardian _____ Phone Number(s) _____
- Emergency contact(s)
Name/relation _____ Phone number(s) _____
 - _____
 - _____
- Notify administration.

Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian, or emergency contact is not present.

Healthcare Provider Signature _____ Phone Number _____ Date _____
Parent/Guardian Signature _____ Date _____

*Emergency medications brought into nurse's office will be sent on field trips. Students who self-carry are responsible for supplying medications during all school-sponsored activities. Allergy Emergency Action Plan must be renewed/reviewed annually. Forms must be dated July 1 or later. Emergency medications must be picked up by a parent/guardian by the last day of school each year (if student does not have permission to self-carry).

CSN Reviewed (Initials/Date) _____