



Student Name _____
D.O.B _____ Grade _____

*****Healthcare provider must complete remainder of this page **except** Parent Signature*****

Allergy to: _____

SIGNS OF AN ALLERGIC REACTION

Systems Symptoms

- MOUTH Itching or swelling of the lips, tongue or mouth
- THROAT Itchy throat, sensation of tightness, swelling, hoarseness, hacking cough
- SKIN Diffuse hives, itchy rash, redness swelling about the face or extremities
- STOMACH Nausea, abdominal cramps, vomiting, diarrhea
- LUNG Shortness of breath, repetitive coughing, wheezing
- HEART Weak pulse, passing out

The severity of symptoms can quickly change. All of the above symptoms can potentially progress to a life-threatening situation.

ACTION FOR MINOR REACTION

1. If only symptom(s) are: A few localized hives, mild itching, or mild nausea: **give ANTIHISTAMINE.** (see dose below)
2. Stay with student; call parents or emergency contacts.
3. Continue to observe child, **if symptoms progress or fail to improve in 30 minutes, follow steps for MAJOR REACTION below.**

ACTION FOR MAJOR REACTION

1. **Inject epinephrine IMMEDIATELY** in thigh.
2. **Call 911** and request an ambulance with epinephrine. Inform them that you have given epinephrine.
3. Give antihistamine (IF NOT VOMITING) and inhaler if history of asthma.
4. Stay with child at all times.
5. Lay child flat and raise legs. If vomiting, allow them to lie on their side or sit up.
6. If symptoms fail to improve or return, **give another dose of epinephrine 5 minutes after the first dose.**
7. Call parents or emergency contacts.

MEDICATIONS/ DOSES

Epinephrine Brand: _____ Epinephrine Dose: 0.3 mg 0.15 mg

Antihistamine Brand or Generic Name: _____ Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

The Student is capable of ___self-administering ___self-possessing the above medication.

Physician/ Healthcare Provider Signature

Date

I give permission to Dexter Community Schools to enter an emergency plan into PowerSchool, to distribute the plan to necessary school district staff, and allow school staff to administer above medication as needed.

Parent/Guardian Signature

Date