RED OAK ISD
SEVERE ALLERGY ACTION PLAN

Name: _____D.O.B._____ Grade/Teacher: _____

HISTORY OF ALLERGY REACTION

Allergic To: _____ Age discovered _____
Allergy Reaction was caused when substance was: ☐ Ingested (eaten) ☐ Contacted (touched) ☐ Inhaled
Describe what happened (list symptoms): _____
_____
Was an emergency injection used for the allergy reaction? _____ If so, when? _____
Was student treated in an ER or hospitalized for an allergy reaction? _____ If so, when? _____
Do you take any special precautions to reduce student's risk of an allergy reaction? _____
_____
_____
Does student have a history of Asthma? No☐ *Yes ☐ (*Higher risk for severe reaction)
To request a special diet or modification of a meal plan at school, please contact your campus nurse.

EMERGENCY CONTACTS

1. Doctor: _____ Phone: _____Fax: _____
2. Name: _____ Phones: _____
   Relation: _____Address: _____
3. Name: _____ Phones: _____
   Relation: _____ Address: _____

IF PARENT/GUARDIAN or PHYSICIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR CALL EMS/911 FOR TRANSPORT TO MEDICAL FACILITY!

SIGNS OF AN ALLERGIC REACTION:

MOUTH Itching and swelling of the lips, tongue, or mouth
SKIN Hives, itchy rash, and/or swelling of the face or extremities
GUT Nausea, abdominal cramps, vomiting, and/or diarrhea
THROAT* Itching and /or a sense of tightness in the throat, hoarseness, and hacking cough
LUNG* Shortness of breath, repetitive coughing, and/or wheezing
HEART* Thready, weak pulse, passing out
The severity of symptoms can quickly change.
All above symptoms can potentially progress to a life-threatening situation.

Place Student's Photo Here

EMERGENCY ACTION PLAN AND MEDICATION AUTHORIZATION
(To be filled in by Physician)

FOR KNOWN OR SUSPECTED SEVERE ALLERGY REACTION/ANAPHYLAXIS:

- Give EPINEPHRINE intramuscularly *(Physician, check one)*
  ☐ **EpiPen 0.3mg** ☐ **EpiPen Jr. 0.15mg** ☐ **Twinject 0.3mg** ☐ **Twinject 0.15mg**
- For mild allergy reactions (skin rash only) or in addition to Epinephrine injection give;
  Antihistamine: _____Dose:_____Route:_____
  Other: _____
- **CALL 911/RESCUE SQUAD**. Notify EMS that a severe allergic reaction has been treated and additional Epinephrine may be needed.

Permission is granted for designated school personnel to administer above medication to student as prescribed by student's physician.

Physician signature: _____ Date: _____
Parent/Guardian signature: _____Date: _____

*My signature indicates that I am giving permission for ROISD staff to contact the physician for additional information, if needed.