Plan expires June 30, 20___

EMERGENCY ACTION PLAN – ALLERGIC REACTIONS/ANAPHYLAXIS

Tri County Area Schools – School Year____-____

Student Name:_____Birthdate:_____

Parent(s)/Guardian(s):_____Phone:_____

Doctor:_____ Phone:_____

Teacher:_____Grade:_____

Allergies:_____

Describe the type of reaction your child has: _____

_____

_____

Emergency Contacts:

Name Phone Mobile

1. _____
2. _____
3. _____

IF YOU SEE THIS		DO THIS
SKIN: swelling	Itching, hives, redness,	Provide the following medications as ordered: Benadryl Yes No Dose:_____ Directions:_____ _____
MOUTH: and/or THROAT: SKIN: swelling STOMACH: LUNG*: breathing HEART*: fainting **some symptoms can be life threatening, ACT FAST, call 911.*	Itching, swelling of lips tongue, excessive saliva Itching, tightness/closure, hoarse voice Itching, hives, redness, Vomiting, diarrhea, cramps Shortness of breath, cough, wheezing or noisy Weak pulse, dizziness,	1. **DO NOT HESITATE TO GIVE EPI PEN** 2. Inject Epi Pen in the student's thigh __EpiPen Jr. – Green Box (for student who weigh less than 66 pounds – use your best judgement) __EpiPen – Yellow Box (for students weighing more than 66 pounds) 3. **CALL 911** 4. Call parent _____ 5. Call School Nurse at 616-302-1187 6. **Stay with the student until help arrives.** 7. Give rescue breathing/CPR if necessary.

Only a few symptoms may be present. Severity of symptoms can change quickly.
****Some symptoms can be life threatening, ACT FAST!***

Parent Signature_____Date:_____

Physician Signature_____Date:_____

District Nurse Signature_____Date:_____