

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Teacher: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Asthmatic:  \* YES or  NO \* High risk for severe reaction

**Step 1: Treatment**

Symptoms	Give checked Medication**	
	**As determined by physician authorizing treatment.	
If a food allergen has been ingested, but no symptoms:	<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 or thready pulse, low blood pressure, 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 area affected), give	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

The severity of symptoms may quickly change. \* All above symptoms can potentially progress to a life-threatening situation. + Potentially life-threatening.

**DOSAGE**

**Epinephrine:** inject intramuscularly (Circle one) EpiPen Epi-Pen Jr Twinject 0.3 Twinject 0.15mg

Epi-pen at Home  Epi-Pen carried  Epi Pen at School  No epi-pen

Antihistamine: give: \_\_\_\_\_ stored \_\_\_\_\_  
Medication/dose/route

Other: \_\_\_\_\_  
Medication/dose/route

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

**Step 2: EMERGENCY CALLS**

- Call 911 and state that an allergic reaction has been treated and additional epinephrine may be needed.
- Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_
- Parents Mom: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_  
Dad: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_
- Emergency Contacts: Name \_\_\_\_\_ Phone Numbers  
 a. \_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_  
 b. \_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

**Do not hesitate to medicate, call rescue squad or transport if required, even if parents/guardian cannot be reached!!**

Parent/Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ (REQUIRED) Date: \_\_\_\_\_

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Teacher: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Asthmatic:  \* YES or  NO \* High risk for severe reaction

**Step 1: Treatment**

Symptoms	Give checked Medication**	
	**As determined by physician authorizing treatment.	
If a STUNG, but no symptoms:	<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 or thready pulse, low blood pressure, 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 area affected), give	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

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Antihistamine: give: \_\_\_\_\_ stored \_\_\_\_\_  
Medication/dose/route

Other: \_\_\_\_\_  
Medication/dose/route

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

- Allow Standard School Procedure for treatment of **any** bee sting or insect bite:
1. Remove the stinger if visible.
  2. Apply a sting kill swab (topical anesthetic).
  3. Apply ice.
  4. Observe the student closely for 20 minutes and return to class if no signs of allergic reaction develop.
  5. Notify the parent.

**Step 2: EMERGENCY CALLS**

1. Call 911 and state that an allergic reaction has been treated and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_

3. Parents Mom: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_

Dad: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_

4. Emergency Contacts: Name \_\_\_\_\_ Phone Numbers \_\_\_\_\_

a. \_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

b. \_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

**Do not hesitate to medicate, call rescue squad or transport if required, even if parents/guardian cannot be reached!!**

Parent/Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date: \_\_\_\_\_