Allergic Reaction Response Plan

Student's Name _____ Grade/Teacher _____

Emergency Contact Information

Mother/Guardian _____ Father/Guardian _____

Home Phone Work Phone Cell Home Phone Work Phone Cell

Physician's Name _____ Physician's Phone _____

Type of allergy:

_____

i.e.: food, insect sting, latex, environmental irritants

Symptoms

Mild	Moderate	Severe
Hives	Swelling of lips/tongue	Severe nausea, vomiting
Itchy rash	Tightness of throat	Severe diarrhea
Minor itching of mouth/throat	Hoarseness	Increased hiccup/cough
Other _____	Swelling at extremity	Wheezing
	Nausea and vomiting	Blue/gray color around mouth
	Siarrhea/abdominal cramps	Differculty swallowing
	Pallor	Faint pulse
	Other _____	Loss of consciousness
		Seizures
		Other _____
Circle student's usual symptoms	*Circle student's usual symptoms*	*Circle student's usual symptoms*

All of these symptoms may progress very quickly to a life-threatening situation.
Do not hesitate to initiate treatment.

Actions Needed

Remove student from allergen if possible
If mild symptoms, escort student to the health office for nurse evaluation.
If moderate or severe symptoms, contact school nurse (ext. 7116) for instructions according to student's IHP.
Activate Medical Response Team if unable to contact school nurse
Call 911 if necessary

Other:

I understand that this information will be shared with school personnel on a need-to-know basis.

_____

Parent signature Date