Confidential Life Threatening Allergy/504 Plan 2015-2016

School: Grade: Teacher: Rides Bus ☐ Yes #_____ ☐ No Address:	**Diagnosis: Life Threatening Allergy to:**	**Student Name:** **DOB:**

Emergency Contact	Relationship to Student	Primary	Work Phone	Cell Phone
	Provider			
Parent E-Mail Address:				

Symptoms of an Allergic Reaction

SKIN	Hives (red welts), itchy rash and/or swelling about face or extremities	**THROAT/ NOSE**	Itching and/or a sense of tightness in throat, hoarseness, nasal drainage or stuffiness
MOUTH	Itching & swelling of the lips, tongue or mouth	**LUNG**	Shortness of breath, repeated or hacking cough, wheezing
GUT	Nausea, abdominal cramps, vomiting, and/or diarrhea	**HEART**	Lightheadedness, dizziness, “passing-out”, weak pulse

❖ ACT IMMEDIATELY for Exposure OR Suspected Exposure ❖

1. **Administer EPI PEN** (Auto-injector to mid-outer thigh)
2. Stay with student.
3. **CALL 911.**
4. Call School Nurse and Parent/Guardian
5. Give Benadryl/Antihistamine if ordered
6. If breathing or pulse STOPS, begin CPR.

To Administer EPI PEN:

- ✓ Pull off safety cap
- ✓ Secure child to safely give injection
- ✓ Using a quick motion and insert into upper thigh
- ✓ Hold for 10 seconds
- ✓ Remove and put back in case
- ✓ Briefly massage injection site

Parents:

- ❖ *For students involved in after school activities, please advise coaches/supervisors of your child’s special medical needs.*
- ❖ *Signature acknowledges parent has reviewed this plan & 504 rights*

Parent Signature _____ Date_____

Teacher Signature _____ Date_____

Nurse Signature _____ Cell #_____ Date_____

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