POTTSGROVE HEALTH SERVICES

ALLERGY UPDATE / EMERGENCY ACTION PLAN

Name _____ **DOB** _____ **GR/HR**_____
School: _____
KNOWN ALLERGIES: _____

_____

COMMON SIGNS OF AN ALLERGIC REACTION
(This is not an exclusive list of symptoms). **CIRCLE ALL** that **APPLY** to your child.
MOUTH Itching, tingling, swelling of the lips, tongue, or mouth
THROAT Itching and/or a sense of tightness in the throat, hoarseness, hacking cough
SKIN Hives, itchy rash, swelling about the face or extremities
GI Nausea, vomiting, abdominal cramps, diarrhea
LUNGS Shortness of breath, repetitive coughing, wheezing
HEART "Thready" pulse, dizziness or fainting
What will your child say to describe his/her symptoms during a reaction?

_____

HISTORY: Is your child undergoing allergy shots? □Yes □ No

Does you child have a history of a delayed reaction? □Yes □ No

Date of last reaction that required medication: _____

PARENTS: **Please instruct your child to tell an adult and the school nurse if they experience signs/symptoms of a severe allergic reaction while at school or on a field trip.**

*****SCHOOL EMERGENCY PLAN: IF INGESTION/EXPOSURE IS SUSPECTED AND/OR SYMPTOMS ARE PRESENT ACT QUICKLY!**

1. ADMINISTER MEDICATION/TREATMENT as per physician order

*Name & Dose of Medication: _____

*Name & Dose of Medication: _____

2. CALL 911 & SCHOOL NURSE _____

3. CONTACT PARENT/GUARDIAN/DESIGNEE

Parent/Guardian Emergency Contact: _____

Telephone (h):_____(w):_____(cell):_____

Parent/Guardian Emergency Contact: _____

Telephone (h):_____(w)_____(cell):_____

Emergency Contact (if Parent/Guardian not available)/Relationship/Telephone Number:

_____

Healthcare Provider/Telephone: _____

Parent Signature_____Date_____

School Nurse Signature_____Date_____