ARISTOI CLASSICAL ACADEMY

Place Photo Here

Severe Allergy Action Plan   School Year:

Student Name: ______________________________

Date of Birth: ______________ Grade: __________ Homeroom Teacher: ______________________

Allery to: ____

Sensitivity: _____ Ingestion only _____Ingestions/ Topical ______Topical _____Airborne

Asthma: _____Yes _____No *HIGHER RISK FOR SEVERE REACTION

History of EpiPen use: _____Yes _____No Comments______________________________

History of Reaction: _____Yes _____No Comments______________________________

Is Special Seating at Lunch Required (Nut-Free Table): _____Yes _____No Comments________________

Are Classroom Accommodations Needed: _____Yes _____No Comments____________________

TREATMENT PLAN

SYMPTOMS:		GIVE CHECKED MEDICATION:	
- MOUTH	Itching, tingling, or swelling of lips, tongue, mouth	_____Epinephrine	_____Antihistamine
- SKIN	Hives, itchy rash, swelling of the face or extremities	_____Epinephrine	_____Antihistamine
- GUT	Nausea, abdominal cramps, vomiting, diarrhea	_____Epinephrine	_____Antihistamine
- THROAT*	Tightening of throat, hoarseness, hacking cough	_____Epinephrine	_____Antihistamine
- LUNG*	Shortness of breath, repetitive coughing, wheezing	_____Epinephrine	_____Antihistamine
- HEART*	Weak pulse, low blood pressure, fainting, pale	_____Epinephrine	_____Antihistamine
- OTHER	______________________________	_____Epinephrine	_____Antihistamine
- If reaction is progressing (several of above areas affected), give		_____Epinephrine	_____Antihistamine

***Potentially Life-Threatening. The Severity of Symptoms Can Quickly Change.**

MEDICATIONS:

Antihistamine: ______________________________ Dose: ______________________

Epinephrine: ________________________ Dose: ______________ Route: ______________

FOR MINOR ALLERGIC REACTIONS:

1. Contact Student Care
2. Administer medications
3. Notify parent / guardian or emergency contact
4. If condition does not improve within 10 minutes, follow steps for major allergic reaction.
5. Document incident thoroughly

FOR MAJOR ALLERGIC REACTIONS:

1. Contact Student Care
2. Administer Emergency Medications
3. Call 9-1-1 and request advance life support for possible anaphylactic reaction
4. Notify parent / guardian or emergency contact
5. Repeat epinephrine after __________ minutes if symptoms have not improved and EMS has not arrived.

Printed Name of Physician ______________________________ Phone Number______________

Physician Signature______________________________ Date____________________

I request the listed medication(s) be administered to my child according to the signed protocol by my child's physician. I hereby give my permission for Student Care personnel or other Aristoi Classical Academy staff members to consult with the prescribing physician regarding the listed medical orders.

Parent / Guardian Signature________________________________ Date_________________

Phone Number_______________________ Work Number________________________

TRAINED STAFF MEMBERS (to be completed by Campus personal)	
Teacher's Name	Date
Teacher's Name	Date
Administrator's Name	Date
Cafeteria Staff's Name	Date
Office Staff's Name:	Date
Other Name:	Date

Student Care Use Only:

____ Added to Medical Alerts

____Self- Carry ____Self- Carry Agreement Completed

____Diet Modification

____RTI ____504 ____ARD

OTHER COMMENTS:

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