MENASHA JOINT SCHOOL DISTRICT

School Health Services

ALLERGY EMERGENCY HEALTH PLAN

Name:_____ **D.O.B:**_____ **School:**_____**Grade:**_____

Allergy to:_____ **Ingestion Touch Aerosol Insect bite (circle those that apply)**

Should epinephrine be given immediately if the student **definitely ate, was in contact, or stung** with the allergen even if **NO** symptoms are noted? ☐ **YES** ☐ **NO (If no, follow procedure listed below)**

Emergency Contact:_____**Phone**:_____

Health Care Provider:_____ **Provider Phone:**_____

System Area	SEVERE SYMPTOMS
LUNG	Shortness of breath, wheezing, repetitive cough
HEART	Pale, blue faint, weak pulse, dizzy
THROAT	Tight, hoarse, trouble breathing/swallowing
MOUTH	Significant swelling of the tongue, face and/or lips
SKIN	Many hives over body, widespread redness
GUT	Repetitive vomiting or severe diarrhea
OTHER	Feeling something bad is about to happen, anxiety, or confusion. *OR a combination of mild symptoms from different body areas.

PROCEDURE

1. **For any of the listed SEVERE symptoms, INJECT EPINEPHRINE IMMEDIATELY**
2. **CALL 911.** Tell the rescue squad epinephrine was given. Request ambulance with epinephrine
3. Consider giving additional medications following epinephrine: Antihistamine, Inhaler (if wheezing)
4. Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side
5. If symptoms do not improve, or symptoms return, a second dose of epinephrine can be given 5 minutes or more after the last dose
6. Alert emergency contacts

System Area	MODERATE/MILD SYMPTOMS
NOSE	Itchy/runny nose, sneezing
MOUTH	Itchy mouth
SKIN	A few hives, mild itch, swelling at site
GUT	Mild nausea/discomfort

PROCEDURE

1. For mild symptoms from 1 system area, follow the directions below:
   a. **Give antihistamines**
   b. Stay with student; alert emergency contacts
   c. If symptoms worsen, give **epinephrine and call 911**
2. For moderate/mild symptoms from 2 or more system areas, **give epinephrine and call 911**

EMERGENCY MEDICATIONS:
Epinephrine Brand:_____ Epinephrine Dose: ☐ 0.15 mg ☐ 0.3 mg

Antihistamine Name: _____Dose:_____Route:_____

_____/_____ _____/_____

Parent/Guardian Signature Date Physician/HCP Authorization Signature Date

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services with this plan, including the administration of medication to my child. I also hereby authorize the school district staff members to disclose my child's protected health information to all staff, chaperones and other non-employee volunteers at the school or at school events and field trips. I hereby give my permission to school personnel to contact the child's physician if necessary. I understand it is my responsibility to see that the medication is delivered to the school office in the original container and to pick up any remaining medication within one week after the last day of the school year. Medication remaining at school will be discarded.(4/12/2019)