STUDENT ALLERGY/ANAPHYLAXIS CARE PLAN

Student Name _____ **Grade** _____

ALLERGY: **Triggers that might start an allergic reaction for this student:** (check appropriate)

__ **Foods (list):** _____

__ **Medications (list):** _____

__ **Latex: *Circle*: Type I (anaphylaxis) Type IV (contact dermatitis)**

__ **Stinging Insects (list):** _____

__ **Other (list):** _____

RECOGNITION OF SYMPTOMS

If food is ingested or contact with allergen occurs and **No** symptoms are immediately noted the staff should continue to observe the student for possible symptoms.

Possible Symptoms: Circle Presenting Symptoms

Mouth:	Itching, tingling, or swelling of lips, tongue, mouth
Skin:	Hives, itchy rash, swelling of the face or extremities
Gut**:**	Nausea, abdominal cramps, vomiting, diarrhea
Throat**:**	Tightening of throat, hoarseness, hacking cough
Lung**:**	Shortness of breath, repetitive coughing, wheezing
Heart**:**	Thready pulse, low BP, fainting, pale, blueness
Neuro**:**	Disorientation, dizziness, loss of consciousness
Other:	_____

The severity of symptoms can quickly progress and become potentially life-threatening

Prescribed Medication (EpiPen): _____

Field Trips: Emergency Allergic Reaction Medication and supplies must accompany student on all field trips. Supervising adult must be instructed on correct use of the medications and bring a copy of the ALLERGY/ANAPHYLAXIS CARE PLAN and Contact Phone Numbers.

(1) Parent to Contact _____

Phone Number(s) _____

(2) Other Person to Contact in Emergency _____

Phone Number(s)_____

Parent/Legal Guardian Signature_____ Date _____