SUMTER COUNTY SCHOOLS HEALTH SERVICES
EMERGENCY ACTION PLAN – ALLERGY
(To be completed by Registered Nurse) **SCHOOL** _____

Grade ____ **Teacher** _____ **Date Initiated** _____
Grade ____ **Teacher** _____ **Date Reviewed** _____
Grade ____ **Teacher** _____ **Date Reviewed** _____

ALLERGY TO: _____. **Length of time condition has existed**_____. **Date Discontinued** _____

Name: _____ **DOB:** _____
Parent #1: _____ **Phone #1:** _____ **Phone #2:** _____
Parent #2: _____ **Phone #1:** _____ **Phone #2:** _____
Emergency Contact #1: _____ **Phone:** _____
Emergency Contact #2: _____ **Phone:** _____
Physician Name: _____ **Phone:** _____
Specialist Name: _____ **Phone:** _____

Reaction occurs if student has following type of contact: ___ Ingestion ___ Skin Contact ___ Inhale ___ Other _____
Asthma: ___ Yes ___ No *(Higher risk of severe reaction if Asthmatic)*

Allergies to:

☐ Food _____ ☐ Medication _____
☐ Insect's _____ ☐ Other _____

SEVERE ALLERGY TO: _____

Medications at School	Medication Storage Location
_____ 0.3 mg _____ or 0.15 mg _____	☐ Clinic/Health room
_____ Dosage:	☐ Classroom
	☐ Self-Carry/Backpack
	☐ Other

Description: **A dramatic, sudden hypersensitive reaction of the body that normally occurs within seconds/minutes of ingestion / exposure to the allergen.**

TREATMENT

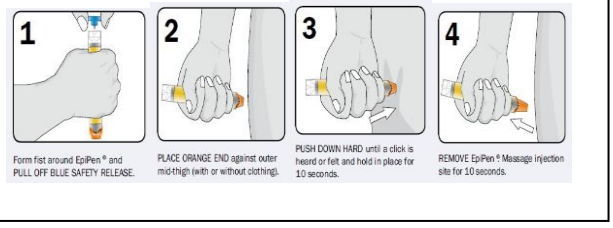
Any SEVERE SYMPTOMS after suspected or known ingestion and/or exposure:
One or more of the following:
LUNG: Shortness of breath, difficulty breathing, wheeze, persistent cough
HEART: Dizzy, blue lips and fingers, weak pulse, confused, faint, pale, fast heart beat
THROAT: Difficulty breathing/swallowing, hoarse, tightness or swelling
MOUTH: Swelling of tongue and/or lips, tingling of lips and tongue
SKIN: Hives, itching, welts, rash over body, redness, swelling
Or combination of symptoms from different body areas:
Skin: Hives, rash, welts, swelling of lips, mouth and eyes
Gut: Vomiting, stomach cramps, diarrhea

1. INJECT EPINEPHRINE IMMEDIATELY
Route : IM _____Amount:_____1 Pen_____
2. Call 911
3. Notify school nurse at ext. _____
4. Notify Administration at ext. _____
5. Call parents
6. Stay with student and keep student warm
7. Administer additional medication

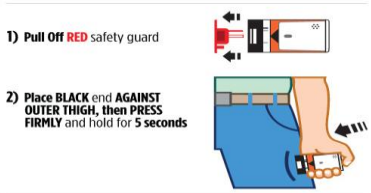
MILD SYMPTOMS:
Mouth: itchy mouth
Skin: Localized rash/hives around mouth/face, mild itching
Gut: Mild discomfort/nausea

1. Remove causative agent
2. Initiate doctor's order of prescribed Medication _____
3. Stay with student; notify nurse and parent/s.
4. If skin irritation, cleanse with soap and water and apply ice.
5. If symptoms progress and become severe use **EPINEPHRINE.** (See above)

EPIPEN

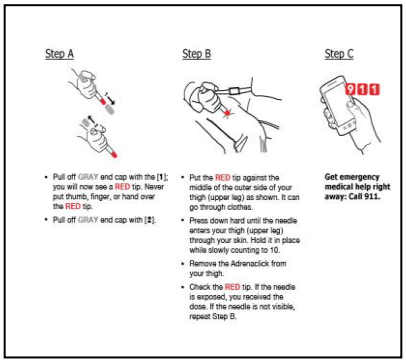


AUVI-Q



***Take emergency medication on all off campus activities.**

ADRENACLICK



EACH INJECTORS NEEDS TO BE REMOVED FORM IT'S CASE BEFORE USE!

Sent Copies To: Teacher: ___Homeroom ___ 1st ___ 2nd ___ 3rd ___4th ___ 5th ___ 6th ___ 7th ___ 8th ___ Clinic ___PE ___Art ___Music ___Cafeteria ___ Bus Driver ___School Nurse Coordinator/Supervisor ___Library ___Coach/PE ___Computer Lab ___Other

Student Name _____ **DOB** _____

*** As parent/guardian by signing this Health Care Plan, I authorize designated Sumter County School personnel, Sumter County Health Department School personnel, and any other contracted health care agencies to provide emergency care for my child and/or to share or exchange medical information as necessary to support the education and continuity of care of my child. I also give permission for the Sumter County Schools to share this information with faculty/staff who are directly involved in my child's education.**

Parent Signature _____ **Date** _____

☐ **Obtained via telephone interview with parent** **School Year** _____

_____ _____

Nurse Signature and Date **School Health Tech Signature and Date**

_____ _____

Teacher Signature and Date **Teacher Signature and Date**

_____ _____

Other Faculty/Staff (Specify) and Date **Other Faculty/Staff (specify) and Date**

***YEAR 2 REVIEW: Update to Individual Emergency Action Plan** **School Year** _____

Status determined by:

- ☐ **Person-to-person interview**
- ☐ **Telephone interview**
- ☐ **Update letter**
- ☐ **No changes to current plan**

_____ _____

Parent Signature and Date **Nurse Signature and Date**

_____ _____

Teacher Signature and Date **Other Faculty/Staff (Specify) and Date**

***YEAR 3 REVIEW: Update to Individual Emergency Action Plan** **School Year** _____

Status determined by:

- ☐ **Person-to-person interview**
- ☐ **Telephone interview**
- ☐ **Update letter**
- ☐ **No changes to current plan**

_____ _____

Parent Signature and Date **Nurse Signature and Date**

_____ _____

Teacher Signature and Date **Other Faculty/Staff (Specify) and Date**

***Note: 1. Significant changes to the plan of care requires a new Individual Emergency Action Plan be completed.**

2. At the beginning of the 4th school year based on the initial date of this plan a new EAP will be written.