FOOD ALLERGY/EMERGENCY ACTION PLAN

If your child has asthma see bottom of page

Student's Name_____Teacher_____

ALLERGIC TO: _____

MEDICAL CONDITION: _____

Please check all that apply

_____Mouth	Itching & swelling of the lips, tongue, or mouth
_____Throat	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
_____Skin	Hives, itchy rash, and/or swelling about the face or extremities
_____Gut	Nausea, abdominal cramps, vomiting, and/or diarrhea
_____Lung	Shortness of breath, repetitive coughing, and/or wheezing
_____Heart	"Thready" pulse, "passing out"

Parent/Guardian is always to be called immediately.

Parent/Guardian Name_____Phone_____

Name_____ Phone_____

Additional Contacts_____Phone_____

ACTION FOR MINOR REACTION

Student has _____ medication in the office.

If symptoms are noted, administer _____ (medication) as noted on prescription/over the counter medicine form. If condition does not improve within 10 minutes, follow steps for Major Reaction noted below.

ACTION FOR MAJOR REACTION

Administer _____ (medication) as noted on prescription/over the counter medicine form and call 911.

Additional directions:_____

_____

_____

Does your child have asthma ___yes ____no

Does he/she require an inhaler at school ___yes ___no (If yes please see reverse side.)

SCHOOL BASED ASTHMA MANAGEMENT PLAN

Student's Name_____**Teacher**_____

Parent/Guardian Name_____Phone_____

Additional Contacts _____Phone_____

_____Phone_____

Does your child require their inhaler before gym class? ___yes ____no

A prescription use form signed by the doctor needs to be on file in the school office allowing for school personnel to administer the inhaler. (Forms are available in the school office).

Additional directions:_____

Parent Signature_____**Date**_____