Syracuse City School District

HEALTH SERVICES
725 Harrison St.
Syracuse, New York 13210
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Allergy Action Plan

Severe Allergy To: _____Weight_____ Date _____

Student's Name: _____ D.O.B. _____ Teacher: _____

Stage I Early signs of an allergic reaction include:

- 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"

Action:

1. If ingestion is suspected, give _____by mouth immediately.
2. Call: Mother _____ Father _____ or emergency contacts

Stage II * Can be life threatening! IF SYMPTOMS DEVELOP IN 2 OR MORE SYSTEMS or IF THROAT, LUNG, OR HEART SYMPTOMS DEVELOP

Action:

1. Give _____ immediately!
2. Call 911
3. Call: Mother _____ Father _____ or emergency contacts
   Or cell phone # _____.
4. Call: Dr. _____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

_____ _____ _____ _____
Parent Signature Date Doctor's Signature Date

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. _____ Relation: _____ Phone: _____ 2. _____ Relation: _____ Phone: _____ 3. _____ Relation: _____ Phone: _____	1. _____ Room _____ 2. _____ Room _____ 3. _____ Room _____

4/07 (22)

EMERGENCY CARE PLAN – FOOD ALLERGY

Student Name: _____ DOB _____ Grade _____

Identified Allergens: _____

Asthma (yes or no) _____ Other relevant health concerns _____

Contact Information:
Mother: Name: _____ Phone _____
Father: Name: _____ Phone _____
Emergency Contact: Name: _____ Phone _____
Additional Contact if needed: _____ Phone _____

School: _____ Nurse: _____ Phone _____

Important: Each allergic reaction may increase in severity from previous reactions. Allergic reactions can increase in severity quickly – provide emergency care are quickly as possible.

AN ALLERGIC REACTION MAY INCLUDE ANY OR ALL OF THESE SYMPTOMS:

- General: Dizziness, loss of consciousness, feeling of panic or doom
- Mouth: Swelling of lips, face, tongue, throat; a report that the mouth "feels hot"
- Breathing: Wheezing, difficulty breathing, congested, cough, tightness of throat
- Stomach: Discomfort, nausea, vomiting, abdominal cramps, diarrhea
- Skin: Hives, swelling, rash

When you see any of the above symptoms, it is important to initiate the following plan of care:
If possible, rinse the area or mouth with large amounts of water.

Provide the following medication as ordered by the student's healthcare provider:

Benadryl □ Yes □ No Dosage: _____

Directions for administration: _____

Epinephrine □ Yes □ No Dosage: _____

Directions for administration: _____

If epinephrine is given, emergency medical services (911) should be accessed immediately. Report that the student is having an allergic reaction and indicate that you require Advanced Life Support with additional epinephrine.

□ Treatment should be initiated immediately following exposure without waiting for symptoms (per healthcare providers orders)
□ Treatment should be initiated only following the appearance of symptoms (per healthcare provider's orders)

Doctor's Name: _____ Phone _____

Preferred Hospital: _____Emergency Care Plan written by: _____

Parent/Guardian Signature: _____ Date: _____

This parent/guardian signature authorizes the nurse to share this information with school staff on a "need to know" basis. In the event of an emergency, care will be initiated and parents will be contacted.

This plan is in effect for the current school year and summer school as needed. *4/07 (22B)*

HEALTH HISTORY
Caring for Students with Food Allergies

Student Name: _____ DOB: _____ Grade: _____

Primary Health Concern: _____

Secondary Health Concern(s): _____

Healthcare Provider's Name: _____ Phone: _____

Diagnosis (note specific allergens): _____

At what age was the student diagnosed with a food allergy? _____ What symptoms led to the diagnosis? _____

Approximately how many allergic reactions has the student experienced? _____

When was his/her last allergic reaction? _____

Has the child been hospitalized as a result of an allergic reaction? ☐ Yes How many times? _____

☐ No

Does the child have an early awareness of the onset of an allergic reaction? _____

What treatment does the child usually require for an allergic reaction? _____

Has the student experienced an allergic reaction at school before? _____

If so, please describe incident: _____

_____

Does the student have asthma? ☐ Yes ☐ No (Asthma can increase the severity of a reaction)

Is there anything else that the school should know to take the best care we can of your student? _____

_____

_____

All school health information is handled in a respectful and confidential manner. May the school health office staff share this information with school staff on a "need to know" basis? ☐ Yes ☐ No

Parent/Guardian Signature _____ Date _____