Lytle ISD School Allergy Action Plan

Student's Name_____DOB_____
Grade_____School_____
Parent Emergency Contact_____(phone)_____
Physician/Healthcare Provider_____(phone)_____

TO BE COMPLETED BY STUDENT'S PARENT:

□ I give permission for my child to carry an EpiPen at school.
□ I give permission for the school nurse and my child's health care provider to exchange information about my child's allergy.
□ Student/family chooses to keep EpiPen in school nurse office.

Parent
Signature_____Date_____

TO BE COMPLETED BY PHYSICIAN/HEALTHCARE PROVIDER: Allergy to:

FOOD: □ Peanuts □ Tree Nuts □ Seafood □ Dairy □Other
Specify_____
INSECT: □ Bees □Other Specify_____
□ Latex
Other Allergy
Specify_____

ACTION FOR MINOR REACTIONS:

Medication

List Symptoms (e.g. rash, swelling, or itching at site)
_____
_____

_____
(Medication/Dose/Route)

□ Contact Parent
□ Observe Student for _____ minutes.

ACTION FOR MAJOR REACTIONS:

□ Epinephrine: inject intramuscularly □ EpiPen □ EpiPen Jr.
□ Other medicine _____

(Medication/Dose/ Route)

□ Call EMS_____

□ Contact Parent

□ Contact Student's Physician

List Symptoms (e.g. difficulty breathing, generalized swelling or itching, wheezing, fainting)

_____

_____

□ This student has the knowledge and skills to carry and use an EpiPen.

□ This student does not have the knowledge and skills to carry and use an EpiPen.

□ Other_____

_____ _____

(Physician/Healthcare Provider Signature) (Date)