

ANAPHYLAXIS/SEVERE ALLERGY ACTION PLAN
Health Services Department
Lincoln Public Schools

Student Name: _____ ID#: _____ Grade: _____

ALLERGEN: _____

Dear Parent/Guardian,

In a review of student health records, a notation concerning anaphylaxis or "severe allergies" was found on your child's health card. Please complete the following information and return it to the school health office. This information will be shared with educational staff to benefit your child's safety and learning at school. If you have any questions, please call the school nurse. Thank you for your assistance.

School Nurse: _____ School Phone: _____ Date: _____

Parent/Guardian Name: _____ Phone (H): _____

Address: _____ Phone (W): _____

Parent/Guardian Name: _____ Phone (H): _____

Address: _____ Phone (W): _____

Emergency Phone Contact #1: _____
Name Relationship Phone

Emergency Phone Contact #2: _____
Name Relationship Phone

Physician Student Sees for Treatment of Allergies: _____ Phone: _____

Other Physicians: _____ Phone: _____

Hospital Preference: _____

DAILY MANAGEMENT PLAN FOR ALLERGIES/ANAPHYLAXIS

Identify the Specific Signs and Symptoms of Allergic Reaction:

- | | | |
|--|---|---|
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Swelling, Where: _____ | How Much: _____ |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Nausea | <input type="checkbox"/> Flushed or Unusually Pale Skin |
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Rash, Where: _____ | <input type="checkbox"/> Other: _____ |

Comments: _____

Past Hospitalization(s) for Severe Allergic Reaction:

Current Medication(s) to Control the Allergy(ies) No Yes, Please List: _____

If Epi-Pen Prescribed, How Many Times Used in the Past Year: _____

EMERGENCY PLANS FOR SCHOOL STAFF

Emergency Action is Necessary When the Student Has the Following Signs and Symptoms:

EMERGENCY MEDICATIONS

| What | Amount | When Given |
|----------|--------|------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |

Contact Parent When: _____

Student to Return to Classroom When: _____

SUGGESTIONS FOR THE SCHOOL ENVIRONMENT

List Any Environmental Control Measures, Premedications and/or Dietary Restrictions for the Student:

Type of Snacks/Foods to be Offered as Alternatives (if allergic to specific food):

How to Handle Special Events (picnics, field trips, etc.):

Equipment at School:

Comments/Special Instructions:

Parent/Guardian Signature: _____ Date: _____



SCHOOL NURSE REVIEW

Date: _____ Signature: _____

Comments: _____

Date: _____ Signature: _____

Comments: _____

Date: _____ Signature: _____

Comments: _____
