Cleburne ISD Health Services
SEVERE ALLERGY ACTION PLAN

Name: ____________________________________ **D.O.B.**__________ **Grade/Teacher:** _________________________

HISTORY OF ALLERGY REACTION

Allergic To: ____ Age discovered _____________
Allergy Reaction was caused when substance was: ___Ingested (eaten) ___Contacted (touched) ___Inhaled
Describe what happened (list symptoms): ____
____
Was an emergency injection used for the allergy reaction? _______ If so, when? ______________________________
Was student treated in an ER or hospitalized for an allergy reaction? _______ If so, when? _______________________
Do you take any special precautions to reduce student's risk of an allergy reaction? ___________________________
____
____
Does student have a history of Asthma? No___ *Yes ___ (*Higher risk for severe reaction)
To request a special diet or modification of a meal plan at school, please contact your campus nurse.

EMERGENCY CONTACTS

1. Doctor: ____________________________ Phone: ______________________Fax: __________________
2. Name: _____________________________ Phones: ____
   Relation: ___________________________Address: ____
3. Name: _____________________________ Phones: ____
   Relation: ___________________________ Address: ____

IF PARENT/GUARDIAN or PHYSICIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR CALL EMS/911 FOR TRANSPORT TO MEDICAL FACILITY!

SIGNS OF AN ALLERGIC REACTION:

MOUTH Itching and swelling of the lips, tongue, or mouth
SKIN Hives, itchy rash, and/or swelling of the face or extremities
GUT Nausea, abdominal cramps, vomiting, and/or diarrhea
THROAT* Itching and /or a sense of tightness in the throat, hoarseness, and hacking cough
LUNG* Shortness of breath, repetitive coughing, and/or wheezing
HEART* Thready, weak pulse, passing out
The severity of symptoms can quickly change.
All above symptoms can potentially progress to a life-threatening situation.

Place Student's Photo Here

EMERGENCY ACTION PLAN AND MEDICATION AUTHORIZATION
(To be filled in by Physician)

FOR KNOWN OR SUSPECTED SEVERE ALLERGY REACTION/ANAPHYLAXIS:

- Give EPINEPHRINE intramuscularly *(Physician, circle one)*
  EpiPen 0.3mg **EpiPen Jr. 0.15mg** **Twinject 0.3mg** **Twinject 0.15mg**
- For mild allergy reactions (skin rash only) or in addition to Epinephrine injection give;
  Antihistamine: _________________________________Dose:___________________Route:_____________
  Other: ____
- **CALL 911/RESCUE SQUAD**. Notify EMS that a severe allergic reaction has been treated and additional Epinephrine may be needed.
  Permission is granted for designated school personnel to administer above medication to student as prescribed by student's physician.
  Physician signature: ____ **Date:** _________________________
  Parent/Guardian signature: ____________________________________**Date:** _________________________

*My signature indicates that I am giving permission for CISD staff to contact the physician for additional information, if needed.