Bellevue Public Schools

B

NRS 1032-3/23

Allergy Action Plan

Student information

Student's name _____ Date of Birth _____

School _____ Grade _____

Please complete this form with current information about your student's allergy, including actions to take should a problem arise. A new action plan is required each school year to be completed on or after May 1.

Contact information

Parent/Guardian 1 _____

Telephone Home _____ Work _____ Cell _____

Email address _____

Parent/Guardian 2 _____

Telephone Home _____ Work _____ Cell _____

Email address _____

Student's physician/health care provider _____

Address _____

Telephone _____ Fax _____

1. What is your student allergic to? _____
   _____
   _____
   _____

2. What are early symptoms which your student experiences when exposed to the allergen? _____
   _____
   _____
   _____

3. How should we respond if your student experiences a problem? _____
   _____
   _____
   _____

4. Is your student's allergy so severe that it requires treatment with emergency medication? (i.e., use of an EpiPen) ☐ Yes ☐ No

   If medication is required at school, please provide the medication with the "Permission for Administration of Medication by School Personnel" form.

Note: If a student's parent/guardian and physician requests that the student self-manage his/her anaphylaxis condition at school, a self-management of anaphylaxis consent/release form must be completed and kept on file at the school. This is required by law.

PLEASE COMPLETE BACK OF PAGE

Allergy Action Plan _____

Student's Last Name Student's First Name

Severity of symptoms can change rapidly and become life-threatening!

Symptoms of Severe Reaction:
Please **circle** your student's symptoms.

Systems:	Symptoms:
Mouth	itching and swelling of the lips, tongue or mouth
Throat	itching and/or sense of tightness in throat, hoarseness, hacking cough
Skin	hives, itchy rash, and/or swelling about the face or extremities
Abdomen	nausea, abdominal cramps, vomiting and/or diarrhea
Lung	shortness of breath, repetitive coughing, and/or wheezing
Heart	loss of consciousness, "thready" pulse

Procedure for Severe Symptoms

1. Call 911 EMS.
2. Administer medication if ordered _____
3. Reassure student.
4. Notify school nurse and parent/guardian.
5. Monitor closely for progression of symptoms.
6. If the student does not get better or continues to get worse, use Nebraska Schools' Emergency Response to Life Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol (at school, during school hours).

Additional comments: _____

_____

_____

_____

Symptoms of Mild Allergic Reaction:

1. Mild hives, itchy rash
2. Runny nose, itchy, watery eyes
3. _____

Procedures for Mild Symptoms

1. Administer medication if ordered: _____
2. Notify school nurse and parent/guardian.
3. Monitor in health office for a minimum of 30 minutes.
4. Alert appropriate staff to watch for progression of symptoms.

Additional comments: _____

_____

_____

_____

I understand and agree this information will be reviewed by the school nurse and shared with school staff when appropriate. The school nurse may contact you or your student's physician/health care provider if additional information or clarification is needed. I authorize the school nurse or designated personnel to follow this insect sting allergy action plan and administer medications as detailed in this plan.

Physician signature_____ Date_____

Parent/Guardian signature_____ Date_____

Reviewed by school nurse_____ Date_____

_____

_____