

The parent/guardian is responsible for providing medications to the school. The school does NOT provide these medications.

Barrow County School System
Allergy / Emergency Action Plan

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

ALLERGY TO: _____

Does this student have Asthma? Yes * No * High risk for severe reaction

◆ SIGNS OF AN ALLERGIC REACTION ◆

At the start of a reaction, the following symptoms may appear alone or in any combination:

- Systems: 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, trouble swallowing
 - **SKIN:** Hives, itching, rash, and/or swelling (usually the face or extremities)
 - **GI:** Nausea, abdominal pain/cramps, vomiting, and/or diarrhea
 - **LUNGS:** Shortness of breath, repetitive coughing, wheezing, chest pain/tightness, nasal congestion, Trouble swallowing, or hay-fever like symptoms
 - **HEART:** Weak and "thready" pulse, low blood pressure, passing out, paleness, light-headed, shock
 - **Other:** Anxiety, sense of doom, headache

The severity of symptoms can quickly change. * All above symptoms can potentially progress to a life-threatening situation.

◆ ACTION ◆

1. If ingestion, exposure or sting is suspected: (Please √ correct action) :
____ administer Epi-Pen and/or ____ give Antihistamine: _____ immediately.
Medication, dose, route)
____ Other: _____

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2. Call 911 or local Emergency Medical Services.
3. Call: Mother _____ Father _____
Or emergency contacts _____
4. Call Dr. _____ at _____

**** DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL EMS
EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED. ****

Parent/Guardian Signature

Date

Healthcare Provider's Signature

Date

EMERGENCY CONTACTS

1. _____
Name Phone
2. _____
Name Phone
3. _____
Name Phone

TRAINED STAFFMEMBERS

1. _____
Name Room or Department
2. _____
Name Room or Department
3. _____
Name Room or Department