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		**TRAINED STAFFMEMBERS**	
1. _____		1. _____	
Name	Phone	Name	Room or Department
2. _____		2. _____	
Name	Phone	Name	Room or Department
3. _____		3. _____	
Name	Phone	Name	Room or Department