Edina KIDS Club/WISE Guys/Sonic • Severe Allergy Action Plan

Please have physician complete this two page form.

Student's Name: _____ Date of Birth: _____ Date: _____ (Student Photo)
School: _____ Grade: _____
Severe Allergy To: _____

Asthmatic: ☐ Yes* ☐ No * High risk for severe reaction History of anaphylactic reaction: ☐ Yes ☐ No
Date of last anaphylactic reaction: _____ # of hospital visits for allergic reaction: _____

Step 1: Treatment

Symptoms		**Give Checked Medication** (To be determined by physician authorizing treatment)	
☐ **Mouth**	Itching, tingling, swelling of the lips, tongue or mouth	☐ **Epinephrine**	☐ **Antihistamine**
☐ **Skin**	Hives, itchy rash, swelling of face or extremities	☐ **Epinephrine**	☐ **Antihistamine**
☐ **Gut**	Nausea, abdominal cramps, vomiting, diarrhea	☐ **Epinephrine**	☐ **Antihistamine**
☐ **Throat***	Tightness of throat, hoarseness, hacking cough	☐ **Epinephrine**	☐ **Antihistamine**
☐ **Lung***	Shortness of breath, repetitive coughing, wheezing	☐ **Epinephrine**	☐ **Antihistamine**
☐ **Heart***	Thready pulse, low blood pressure, fainting, pale, blueness	☐ **Epinephrine**	☐ **Antihistamine**
☐ **Other**			
➢ If a food allergen has been ingested, but no symptoms: _____		☐ **Epinephrine**	☐ **Antihistamine**
➢ If exposure to allergen other than by ingestion (skin/inhalation) _____		☐ **Epinephrine**	☐ **Antihistamine**

If reaction is progressing (several of the above areas affected), give ☐ **Epinephrine** ☐ **Antihistamine**

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

Medication and Dosage

Epinephrine: inject intramuscularly (circle one) EpiPen® 0.3mg EpiPen® Jr. 0.15mg Twinject™0.3mg Twinject™0.15mg

Antihistamine: give _____
Medication/dose/route/ **repeat when?**

Other: give _____
Medication/dose/route/ **repeat when?**

Physician Signature (required) _____ **Date:** _____

Print Physician/Clinic Name: _____ **Phone:** _____

Additional Information (if needed)

Step 2: Emergency Calls

1. **Call 911 immediately. 911 MUST BE CALLED if EpiPen®is administered. State that an allergic reaction has been treated and additional epinephrine may be needed.**
2. **Dr. _____ at _____ Transport to: _____ Hospital**
3. **Emergency contacts:**

Parents/Other	**Emergency Phone Numbers(s)**
1. _____	**a)** _____ **b)** _____
2. _____	**a)** _____ **b)** _____
3. _____	**a)** _____ **b)** _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Authorization

1. I agree with the above Severe Allergy Action Plan and I request that the above medication/s be given during KIDS Club/WISE Guys/Sonic as ordered by my child's physician/licensed prescriber.
2. I give permission for my child to carry the above medication in their backpack. ☐Yes ☐ No
3. I request that the above medication be sent on field trips. ☐Yes ☐ No
4. I will notify KIDS Club/WISE Guys/Sonic if medication is stopped.
5. I give permission for the medication/s to be given by KIDS Club/WISE Guys/Sonic personnel.
6. Legally I may refuse to sign the Severe Allergy Action Plan. If I refuse to sign, KIDS Club/WISE Guys/Sonic will not be able to administer the prescribed medication.
7. This consent may be revoked at any time by sending a written notice to KIDS Club/WISE Guys/Sonic.

_____ _____

Parent /Guardian Signature **Date**

Permission for Release of Information

1. I give permission for the KIDS Club/WISE Guys/Sonic staff to communicate, as needed, with staff about my child's medical condition/s and the action of the medication/s.
2. I give permission for the KIDS Club/WISE Guys/Sonic staff to contact my child's physician/licensed prescriber regarding questions about the above listed medication/s or medical condition/s being treated by medication/s.

_____ _____

Parent /Guardian Signature **Date**