Edina KIDS Club/WISE Guys/SONIC - Severe Allergy Action Plan

Please have physician complete and sign this two page form.

Student's Name: _____ Date of Birth: _____
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:

What specifically would trigger an allergic reaction? (i.e. ingesting, touching, proximity to a particular allergen, etc.?)

What is the best way to avoid an allergic reaction? (i.e. no foods containing the allergen, must sit at an allergen-free table for meals, cannot be in the same room with the allergen, etc.)

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**
➢ 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 (to be made by program staff)

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 HAVE CHILD TRANSPORTED TO EMERGENCY 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 or changed.
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 school 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/SURGE 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**