

Deerfield School District
EMERGENCY PLAN FOR SEVERE ALLERGIES
(Please return this form to your child's school)

Student Name _____ Physician's Name _____

Birthdate _____ Male ___ Female _____ Physician's Address _____

School _____ Grade _____

Parent/Guardian _____ Physician's phone _____

Home Phone _____ Work Phone _____ Physician's Fax _____

The above student is at risk for severe allergic reaction to:

Bee/wasp/insect sting _____ Medication (specify) _____

Food (specify) _____ Other (specify) _____

Usual Symptoms seen _____

Physician: Please check option A , B, or C for school staff to follow:

Type of EpiPen ordered: ___ Epi-pen (0.3 mg epinephrine) or ___ Epi-Pen Jr. (0.15 mg epinephrine)

___ A. Give Epi-pen immediately upon exposure to above listed allergen.

___ B. After exposure, give Epi-pen should **any** of the following symptoms occur:

- | | |
|---|--|
| √ difficulty breathing or wheezing | √ change in voice quality (hoarseness, high pitch, coughing) |
| √ swelling of the lips, tongue, or throat | √ raised rash (hives) which may progress to areas away from
the site of a sting (if caused by bee/wasp sting) |

___ C. Give the following medication (i.e. Benadryl) for the following mild symptoms _____

Name of Medication _____ Dose _____

Then administer Epi-Pen should any of the following severe symptoms occur: _____

When giving Epi-Pen immediately do the following in this order:

1. Give Epi-Pen injection
2. Call the Rescue Squad (911) to transport and Treat student for shock
3. Notify parent/guardian
4. Notify school nurse

NOTE: The 1983 Wisconsin Act 334 states that no school employee except a health care professional (this does not include health aides) may be required to administer a drug or prescription drug to a student by any means other than ingestion. The Epi-Pen administration will be done at school by a volunteer person following the above guidelines authorized by the parent and physician with the following signatures:

PARENT/GUARDIAN SIGNATURE _____ DATE _____

PHYSICIAN SIGNATURE _____ DATE _____

(or prescribing health care practitioner)