BERLIN BROTHERSVALLEY S.D.

Student Name: Date of Birth: School Year:

School Name: Grade: Teacher:

Allergy To: **Asthmatic: ☐ YES ☐ NO**

STEP 1: TREATMENT – To be completed by Physician

Symptoms:	**Give checked Medication (to be determined by Physician)**	
If exposure to an allergen occurs, but no symptoms	☐Epinephrine	☐Antihistamine
Mouth: itching, tingling, or swelling of lips, tongue, mouth	☐Epinephrine	☐Antihistamine
Skin: Hives, itchy rash, swelling of face or extremities	☐Epinephrine	☐Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐Epinephrine	☐Antihistamine
Throat: tightening of throat, hoarseness, hacking cough	☐Epinephrine	☐Antihistamine
Lungs: shortness of breath, repetitive coughing, wheezing	☐Epinephrine	☐Antihistamine
Heart: weak or thready pulse, low blood pressure, fainting, pale, blueness	☐Epinephrine	☐Antihistamine
Other * Call 911 an Parent	☐Epinephrine	☐Antihistamine
If reaction is progressing (several of the above areas affected)	☐Epinephrine	☐Antihistamine

*Potentially Life-threatening, the severity of symptoms can quickly change.

Epinephrine-inject intramuscularly	☐ Epi-Pen 0.3mg	☐ Epi-Pen JR. 0.15 mg
Antihistamine	☐ Benadryl	Dose_____mg

Repeat Epi-Pen ☐YES ☐NO in 15 minutes if EMS has not arrived -2 kits will be needed in school

STEP 2: EMERGENCY CALLS

CALL 911/ TRANSPORT PATIENT TO THE ER

ALERT EMERGENCY CONTACTS

Mother: Home: Work: Cell:

Father: Home Work: Cell:

Other: Name: Relationship: Phone #:

_____ _____

DATE PHYSICIAN'S SIGNATURE