

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	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Mouth: itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Skin: Hives, itchy rash, swelling of face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Throat: tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Lungs: shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Heart: weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Other * Call 911 an Parent	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
If reaction is progressing (several of the above areas affected)	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

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

Epinephrine-inject intramuscularly	<input type="checkbox"/> Epi-Pen 0.3mg	<input type="checkbox"/> Epi-Pen JR. 0.15 mg
Antihistamine	<input type="checkbox"/> 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