# Satellite Beach United Methodist Preschool
# Severe Allergy Emergency Action Plan

**Diagnosis**: SEVERE ALLERGIES **Allergic to**: _____

**Reaction**: _____

Asthma: yes/no_____ (can increase risk for severe reaction.)

Student Name: _____ DOB: _____

Teacher Name:_____ Room: _____

Parent / Guardian Name: _____

Home Phone: _____ Work / Cell Phone: _____

Home Address: _____

Health Care Provider: _____ Phone: _____

**Person(s) To Be Notified In Case Of Emergency:**

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Medication(s): _____

Dosage(s) / Time Given: _____

Route:_____

Location of Medication (*teacher fills out*): _____

**For Food Allergy Only:**

Can student be in the same room as the allergen (yes / no)

Can Student Eat:

- Foods with packaging saying it may contain allergen (yes / no)
- Foods that were processed in a shared facility with allergen (yes / no)
- Foods that were processed on shared equipment with allergen (yes / no)

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| If You See This… | Do This… |
|---|---|
| **Mouth**: Itching/tingling or swelling of the lips and/or tongue<br><br>***Throat**: itching, sense of tightness/closure, hoarseness, hacking cough<br><br>**Skin**: Hives, redness, itchy rash, swelling of face or extremities<br><br>**Gut**: Nausea, cramping, vomiting, or diarrhea<br><br>***Lung**: Shortness of breath, coughing/wheezing<br><br>***Heart**: Thready pulse, dizziness, passing out, low blood pressure, blueness | • Notify staff as needed<br>• Give medication as prescribed<br>• Administer Epi-Pen if two or more reactions are present, and/or if one life-threatening reaction is present<br><br>• If no Epi-Pen is available **CALL 911**<br>• If Epi-Pen is used **CALL 911**<br>• Contact parent<br><br>*Some symptoms may be life-threatening. ACT FAST! |

Parent / Guardian Signature: _____ Date: _____

Director Signature: _____ Date: _____