CHICAGO PUBLIC SCHOOLS CPS

OSES Office of Special Education & Supports

Emergency Action Plan

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

Student's ID#: _____ **Grade:** _____ **Room/Teacher:** _____

Allergic to: _____

Asthmatic: Yes*☐ No ☐ * Higher risk for severe reaction

♦ STEP 1: TREATMENT ♦

Symptoms:		Give Checked Medication: (To be determined by physician authorizing treatment)
NONE:	If a food allergen has been ingested, but *no symptoms*	☐Epinephrine ☐Antihistamine
LUNG†:	shortness of breath, wheezing, or hacking cough	☐Epinephrine ☐Antihistamine
HEART†:	pale, blue, faint, weak pulse, dizzy, confused	☐Epinephrine ☐Antihistamine
THROAT†:	tightening of throat, hoarseness, or trouble swallowing	☐Epinephrine ☐Antihistamine
MOUTH:	itching, tickling, or swelling of lips, tongue and mouth	☐Epinephrine ☐Antihistamine
SKIN:	hives, itchy rash, swelling of the face or extremities	☐Epinephrine ☐Antihistamine
ABDOMEN:	nausea/ vomiting, abdominal cramps, or diarrhea	☐Epinephrine ☐Antihistamine
OTHER†:	_____	☐Epinephrine ☐Antihistamine
If reaction is progressing (several of the above areas affected), give:		☐Epinephrine ☐Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening

Dosage:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen®Jr. Twinject™0.3mg Twinject™0.15mg

Antihistamine: give (medication/dose/route)_____

Other: give (medication/dose/route)_____

♦ STEP 2: EMERGENCY CALLS ♦

1. Call 911: State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Dr. _____ at _____
3. Emergency contacts:

Name/Relationship	Phone Number(s)
a. _____	1._____ 2._____
b._____	1._____ 2._____
c._____	1._____ 2._____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date_____

Doctor's Name (Printed)_____ Phone # _____

Doctor's Signature _____ Date_____

(Required)