San Ramon Valley Unified School District
699 Old Orchard Drive/Danville, CA 94526

LIFE-THREATENING ALLERGIES
MEDICATION ORDERS AND EMERGENCY HEALTH CARE PLAN

Place Student Picture Here

ALLERGY TO:____

STUDENT'S NAME: ______________________________ **BIRTH DATE** _______ **Grade**________

Asthmatic circle **yes*** **no** *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems: **Symptoms:**

- **MOUTH** itching & swelling of the lips, tongue, or mouth
- **THROAT*** itching and/or a sense of tightness in the throat, hoarseness, & hacking cough
- **SKIN** hives, itchy rash, and/or swelling about the face or extremities
- **GUT** nausea, abdominal cramps, vomiting, and/or diarrhea
- **LUNG*** shortness of breath, repetitive coughing, and/or wheezing
- **HEART*** "thready" (weak) pulse, "passing-out"

The severity of symptoms can quickly change.
***All above symptoms can potentially progress to a life-threatening situation!**

ACTION IF INGESTION/EXPOSURE IS SUSPECTED:

1. **GIVE** ____
   medication/dose/route
2. **GIVE** ____
   medication/dose/route

Student may carry Epi-Pen on his/her person while at school MD initial: YES____ NO____

Student is trained in Epi-Pen administration MD initial: YES____ NO____

Student may self medicate when possible* **(with School Nurse or Administrator approval)** MD initial: YES____ NO____

3. **CALL 911 (notify EMS of any medication given)**
4. **CALL Parent** ______________________________**or emergency contacts**
   Name and phone number(s) (see attached)
5. **Other MD instructions**____

____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 EVEN IF PARENTS CANNOT BE REACHED

AUTHORIZING MD SIGNATURE:______________________________**DATE:**_______

MD NAME & ADDRESS STAMP:

Student:
I agree with the above allergy plan. Signature: ______________________**DATE:**______

Parent:
I agree with the above allergy plan. Signature: ______________________**DATE:**______

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