**Ocean Springs School District**

**Allergy History/Action Form**

**Student Name:_____**

List All Allergies: _____

Other Medical Conditions: _____

Asthmatic? _____ Yes (Higher risk for severe reaction) _____ No

**CURRENT MEDICATION PROFILE:**

Drug Name: _____ Amount: _____ How Often: _____

Drug Name: _____ Amount: _____ How Often: _____

Drug Name: _____ Amount: _____How Often: _____

Medication side effects: _____

**DESCRIPTIONS / SYMPTOMS:**

Please rate the severity of the allergy (1 mild, 10 Severe): _____

Please describe a typical reaction (signs and symptoms): _____

_____

**PLEASE FILL OUT THE FOLLOWING IF YOU NEED AN EPI PEN OR ANTIHISTAMINE FOR SYMPTOMS**

| **Symptom:** | **Give Checked Medication** |
|---|---|
| If an allergen has been ingested, *but no symptoms* | ____ Epi Pen ____ Antihistamine |
| Mouth itching, tingling or swelling of lips, tongue, mouth | ____ Epi Pen ____ Antihistamine |
| Skin hives, itchy rash, swelling of the face or extremities | ____ Epi Pen ____ Antihistamine |
| Gut nausea, abdominal cramps, vomiting, diarrhea | ____ Epi Pen ____Antihistamine |
| Throat = Tightening of throat, hoarseness, hacking cough | ____ Epi Pen ____ Antihistamine |
| Lung = Shortness of breath, repetitive crouching, wheezing | ____Epi Pen ____Antihistamine |
| Heart = Thready pulse, low blood pressure, fainting, pale, blueness | ____Epi Pen ____ Antihistamine |
| Other: _____ | ____ Epi Pen ____ Antihistamine |
| If reaction is progressing (several of the above areas affected) | ____ Epi Pen ____ Antihistamine |

**If you require medication at school for a possible allergic reaction please complete a Medication Permission Request Form**

**ALLERGY HISTORY:**

Age when diagnosed: _____ Date of last severe allergy episode:_____

Any Activity Restrictions: _____

**EMERGENCY CONTACTS:**

1. _____ Relationship: _____Phone: _____

2. _____ Relationship: _____Phone: _____

3. _____ Relationship: _____Phone:_____

**IF UNABLE TO CONTACT PARENT/GUARDIAN WITH NUMBERS LISTED ABOVE WITHIN A REASONABLE AMOUNT OF TIME, OR IF THE EPI PEN IS USED 911 WILL BE CALLED!**

**THE FOLLOWING IS TO BE FILLED OUT BY THE SCHOOL NURSE**

TRAINED STAFF MEMBERS

1. _____ Room: _____

2. _____Room: _____

3. _____ Room: _____

EPI PEN AND EPI PEN JR DIRECTIONS

1. PULL OFF GRAY ACTIVATION CAP
2. HOLD BLACK TIP NEAR OUTER THIGH (ALWAYS APPLY TO THIGH)
3. SWING AND JAB FIRMLY INTO OUTER THIGH
4. UNTIL AUTO-INJECTOR MECHANISM FUNCTIONS.
5. HOLD IN PLACE AND COUNT TO 3. REMOVE THE EPI PEN UNIT AND MASSAGE THE INJECTION AREA FOR 10 SECONDS.

## CALL 911