SCHOOL DISTRICT OF NEW LONDON - HEALTH SERVICES

LATEX ALLERGY Action Plan – LATEX ALLERGY

CONFIDENTIAL

Student's Name_____Grade_____School_____ year_____

Parent/Guardian: _____Phone # Work: _____Home #_____

Physician: _____Phone #_____

Family member/Friend-aware of child's condition-Name: _____Phone#_____

Symptoms of my child's allergic reaction:_____

Date of last allergic reaction: _____

Does your child require medication at school if he/she comes in contact with latex? ☐ Yes ☐ No

Please tell us what you want us to do in case of an allergic reaction at school.
(Please check all that apply)

☐ Wash contact area with soap and water

Symptoms:	**Give Checked Medication:**
If contact with latex, but NO symptoms:	use ☐ Epinephrine ☐Antihistamine
Mouth: itching, tingling or swelling of lips, tongue, mouth:	use ☐ Epinephrine ☐ Antihistamine
Skin: hives, itchy rash, swelling of the face or extremities:	use ☐ Epinephrine ☐Antihistamine
Gut: nausea, abdominal cramps, vomiting, diarrhea:	use ☐ Epinephrine ☐ Antihistamine
***Throat:** Tightening of throat, hoarseness, hacking cough:	use ☐ Epinephrine ☐ Antihistamine
***Lung:** Shortness of breath, repetitive coughing, wheezing:	use ☐ Epinephrine ☐Antihistamine
***Heart**: Fainting, pale, blueness, weak or thready pulse, low blood pressure:	use☐ Epinephrine ☐ Antihistamine
***other**: _____	use☐ Epinephrine ☐ Antihistamine
If reaction is progressing (several of the above areas affected)	use☐ Epinephrine ☐ Antihistamine

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

Dose of Epinephrine: ☐ 0.15mg IM ☐ 0.3mg IM **Dose of Antihistamine:** _____

Other (e.g., inhaler-bronchodilator if asthmatic:)_____

☐ Notify parent by: ☐Send note home ☐Call parent by phone
☐ Allow to rest for _____ minutes.
☐ Call 911 if: _____
☐ Other/Comments: _____

(If medication is needed at school, and/or field trips/extracurricular activities, you must have a supply of the medication and the permission form signed by the parent and your child's doctor on file for this school year.)

Parent Signature_____Date_____

School Nurse Signature _____Date of review_____

Physician Signature _____Date _____

Upon completing this form, please print the form and hand it in at registration OR save it and email the form to Jenny Penn MSN, RN at jpenn@newlondon.k12.wi.us. If medication is needed for this concern, you must also fill out a medication consent form. Thank you
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