

ALLERGY/ANAPHYLAXIS ACTION PLAN

Student Name _____ D.O.B. _____ Teacher _____

Student
PhotoSchool Nurse _____ Phone Number _____
Health Care Provider _____ Preferred Hospital _____History of Asthma No Yes-Higher risk for severe reaction**ALLERGY:** (check appropriate) To be completed by Health Care Provider

- Foods (list):**
 Medications (list):
 Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)
 Stinging Insects (list):

RECOGNITION AND TREATMENT

Chart to be completed by Health Care Provider ONLY		Give CHECKED Medication	
If food ingested or contact w/ allergen occurs:		Epinephrine	Antihistamine
No symptoms noted	<input type="checkbox"/> Observe for other symptoms		
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut+	Nausea, abdominal cramps, vomiting, diarrhea		
Throat+	Tightening of throat, hoarseness, hacking cough		
Lung+	Shortness of breath, repetitive coughing, wheezing		
Heart+	Thready pulse, low BP, fainting, pale, blueness		
Neuro+	Disorientation, dizziness, loss of consciousness		
If reaction is progressing (several of the above areas affected), GIVE:			
<i>The severity of symptoms can quickly change. +Potentially life-threatening.</i>			

DOSAGE:**Epinephrine:** Inject into outer thigh 0.3 mg OR 0.15 mg**Antihistamine: Diphenhydramine (Benadryl®)** _____ ml. To be given by mouth *only if able to swallow.***Other:** _____

This child has received instruction in the proper use of the Auto-injector: EpiPen® or Twinject® (circle one). It is my professional opinion that this student **SHOULD** be allowed to carry and use the auto-injector independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the auto-injector is self-administered.

It is my professional opinion that this student **SHOULD NOT** carry an auto-injector.

Health Care Provider Signature _____ Phone: _____ Date _____

EMERGENCY CALLS

- 1. Call 911.** State that an allergic reaction has been treated, and additional epinephrine may be needed.
- 2. Call parents/guardian** to notify of reaction, treatment and student's health status.
- 3. Treat for shock.** Prepare to do CPR.

Side 2: To Be Completed by Parent/Guardian, Student and School

Allergy/Anaphylaxis Action Plan (continued) Student Name _____ D.O.B. _____

Parent/Guardian AUTHORIZATIONS

- I want this allergy plan implemented for my child; **I want my child to carry an auto-injector** and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of an auto-injector.
- I want this plan implemented for my child and I **do not** want my child to self-administer epinephrine.
- It is recommended that back up medication be stored with the school/school nurse in case a student forgets or loses auto-injector and/or antihistamine. The school district is not responsible or liable if backup medication is not provided to the school/school nurse and student is without working medication when medication is needed.

Parent/Guardian Signature: _____ Phone: _____ Date: _____

Student Agreement:

- I have been trained in the use of my auto-injector and allergy medication and understand the signs and symptoms for which they are given;
- I agree to carry my auto-injector with me at all times;
- I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) **IMMEDIATELY** when my auto-injector (epinephrine) is used;
- I will not share my medication with other students or leave my auto-injector unattended;
- I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature: _____ Date _____

Approved by Nurse/Principal Signature: _____ Date _____

Your signature gives permission for the nurse to contact and receive additional information from your health care provider regarding the allergic condition(s) and the prescribed medication.

DELEGATION:

I, parent of the above named student, delegate to the staff members named below the task of administering an auto-injector to my child should he/she show signs and symptoms that might be related to an allergic reaction. I understand that non-licensed staff members will be trained by the school nurse to recognize signs of anaphylaxis and to administer an auto-injector should it be needed. I also understand that personnel will call 911 if an auto-injector is needed. I am delegating this effective today and lasting for the time my child attends this school.

Parent/Guardian Signature: _____ Phone: _____ Date: _____

STAFF MEMBERS TRAINED

Name	Title	Location/Room #	Trained By

EMERGENCY CONTACTS

	Name	Home #	Work #	Cell #
Parent/Guardian				
Parent/Guardian				
Other:				
Other:				