CARMEL CLAY SCHOOLS
5201 E. Main St. · Carmel, IN 46033 · (317) 844-9961

ALLERGY ACTION PLAN

Place Child's Picture Here

Student's Name: _____ DOB: _____

School: _____ Teacher/Grade: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction, complete asthma action plan)** ☐ **No**

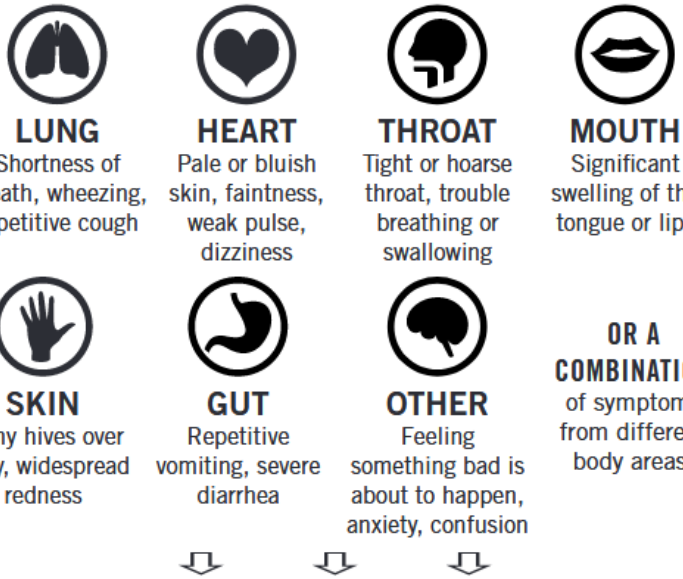
NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Please Check the Appropriate Allergen(s):

☐ Dairy ☐ Peanuts
☐ Bee/Insect Stings ☐ Eggs ☐ Shellfish ☐ Tree Nuts (almonds, pecans, walnuts, etc.)
☐ Latex ☐ Soy ☐ Wheat ☐ Other Food(s): _____
☐ Allow food "processed in a facility with" allergen ☐ Allow food that "may contain" allergen
☐ Allow food "made on shared equipment" as allergen

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG Shortness of breath, wheezing, repetitive cough

HEART Pale or bluish skin, faintness, weak pulse, dizziness

THROAT Tight or hoarse throat, trouble breathing or swallowing

MOUTH Significant swelling of the tongue or lips

SKIN Many hives over body, widespread redness

GUT Repetitive vomiting, severe diarrhea

OTHER Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE Itchy or runny nose, sneezing

MOUTH Itchy mouth

SKIN A few hives, mild itch

GUT Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

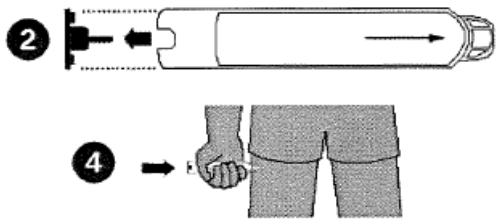
Antihistamine Dose: _____ mg _____

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

_____

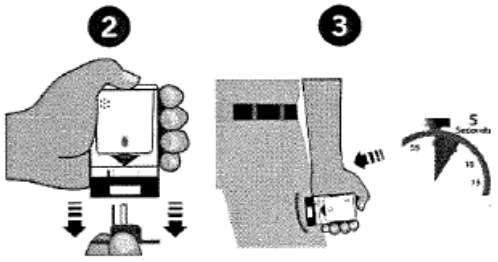
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

Additional Allergy Comments/Instructions:

IF YOU INJECT EPINEPHRINE, CALL 911 AND PARENTS.

Parent/Guardian: _____ Phone: _____

Emergency Contact: _____ Phone: _____

☐ **Yes** ☐ **No** This student has been trained in the use of the medication(s) above and he/she may carry and self-administer if needed, for life threatening allergic reaction.

_____ _____ _____

ALLERGY CARE PROVIDER SIGNATURE **PLEASE PRINT PROVIDER NAME** **DATE**

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

_____ _____

PARENT SIGNATURE **DATE**