Allergy/Anaphylaxis Action Plan

Student Photo

Student Name: _____ DOB _____

TO BE COMPLETED BY LICENSED HEALTHCARE PROFESSIONAL

Allergy to: _____

Asthma *Yes___ No___ ***Higher risk for severe reaction**

♦ STEP 1: RECOGNITION AND TREATMENT ♦

If suspected ingestion of food or contact with allergen occurs, give checked medication:

	Symptoms	Epi-pen	Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of face or extremities		
Gut†	Nausea, abdominal cramps,vomiting, diarrhea		
Throat†	Tightening of throat, hoarseness, hacking cough		
Lung†	Shortness of breath, coughing, wheeze		
Heart†	Thready pulse, low BP, fainting, pale, blue, dizzy		
Neuro†	Disorientation, dizziness, loss of consciousness		
If reaction progresses (several above areas affected) **GIVE:**			

Severity of symptoms can change quickly. †Potentially life-threatening

Dosage:

Epinephrine: Inject IM using auto-injector into outer thigh (check one):

EpiPen®0.3mg ☐ EpiPen Jr.® 0.15mg ☐

☐ **Administer 2nd dose if symptoms do not improve in _____ minutes.**

Other: _____

Medication/ Dose/ Route

The student has been instructed and is capable of carrying /self-administration of her Epi-Pen. YES ☐ NO ☐

* *

Licensed Health Care Professional authorizing administration of above medications:

_____/_____ _____

Signature / Print Name Date

_____ _____ _____

Address Phone FAX

♦ STEP 2: EMERGENCY CALLS ♦

1. **Call 911.** State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Call parent/guardian to notify of reaction, treatment and student's health status.

**** Do not hesitate to administer emergency medication and call 911 even if a parent/guardian cannot be reached.***

STEP 3: MONITORING

Stay with student. For severe reaction, treat for shock and prepare for CPR.

Please complete both sides of this form.

SIDE 2: TO BE COMPLETED BY PARENT/GUARDIAN, STUDENT AND SCHOOL

Allergy/anaphylaxis Action Plan (cont) Student Name: _____ DOB _____

Parent/Guardian Authorizations :

☐ **I authorize the school nurse to share this information with faculty and staff, to implement the Allergy Action Plan, to administer medication, and to contact my daughter's health care provider as necessary.**

☐ **I understand that as the parent/guardian, it is my responsibility to contact the school nurse of any changes to the plan.**

☐ **I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.**

☐ **I understand the recommendation that backup medication be stored with the school/school nurse in the event a student forgets or misplaces her emergency medication(s) i.e.Epi-Pen; rescue inhaler**

Please check one box:

☐ I authorize my daughter to carry and self-administer her Epi-Pen if approved by the school nurse.	☐ I **DO NOT** authorize my daughter to carry and self- administer her Epi-Pen.

_____ _____ _____

Parent/Guardian Signature Date Emergency phone number(s)

Student Agreement:

☐ I have been trained in the use of my Epi-Pen and allergy medication and understand the signs and symptoms for which they are prescribed.

☐ I agree to carry my Epi Pen with me at all times.

☐ I will notify a responsible adult (nurse, teacher, coach, etc) IMMEDIATELY when Epi-pen is used.

☐ I will not share my medication with other students or leave my Epi-Pen unattended.

_____ _____

Student Signature Date

□ Back-up medication is stored at school. □ YES □ NO

TRAINED STAFF MEMBERS

_____ _____ _____

_____ _____ _____

Directions for Epi-Pen Use

1. Pull off blue/gray safety cap.
2. Hold orange/black tip to outer thigh. (Always use outer thigh);
3. Press firmly against outer thigh until auto-injector mechanism functions and hold in place for 10 seconds.
4. Remove Epi-pen and massage injection site for 10 seconds.

* After Epi-Pen use, CALL 911/EMS.

6. Stay with student. Have student lie down and elevate legs as necessary.

* Call emergency contact. Name: _____ Phone _____

* Give allergy action plan and Epi-Pen to emergency responders.