

GOOD SHEPHERD EPISCOPAL SCHOOL ALLERGY ACTION PLAN

Name _____ D.O.B _____ Grade _____ School Year _____ Student picture

Allergic To _____

What Triggers Allergy? Ingestion Contact Airborne

Specific and Detailed Ingestion/Exposure Symptoms:		
Give checked medications (to be determined by physician authorizing treatment)		
If a food allergen has been ingested but no symptoms:	<input type="checkbox"/> Observe	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
If student has been exposed to food allergen:	<input type="checkbox"/> Observe	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
Mouth: Itching, tingling or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Throat*: Tightening of the throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Lung*: Shortness of breath, repetitive cough, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Heart*: Weak, thready pulse, low blood pressure, fainting, pale blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Other*	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
If Reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

*Potentially life threatening. The severity of the symptoms can change quickly. Monitor for side effects of epinephrine injection: nervousness, palpitations, fast heart rate, sweating, tremor, anxiety, dizziness, headache, nausea, vomiting or weakness.

**Medication Dosage

Epinephrine: inject intramuscularly Epi-Pen 0.3 mg Epi-Pen Jr. 0.15mg

Give 2nd epinephrine dose after _____ minutes if no improvement and EMS has not arrived.

Antihistamine: give _____ medication (liquid or pill), dose, route

Other: give _____ medication (liquid or pill), dose, route

1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Emergency Contacts (listed below)

	Name	Phone #	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Physician Designation of Rescue Drug

I have prescribed an epinephrine auto-injector for the student named here for use on an as needed basis. In recognition of the possible need to promptly administer this drug while in attendance at Good Shepherd Episcopal School, when a trained medical professional may not be available, I acknowledge that circumstances may arise in which unlicensed personnel who have been trained by a medical professional, including but not limited to emergency medical personnel, a physician and/or a registered nurse, may need to administer an epinephrine auto-injector to the named student.

I agree / I do not agree (check one) Physician Initials _____ Parent Initials _____

Physician Name _____ Phone _____

Physician Signature _____ Date _____

**All medications must be current, if expired medications are not replaced immediately, student will not be allowed to attend school at Good Shepherd Episcopal School.

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Background Information (Completed by parent or physician)

1. Please describe the circumstances under which you became aware that your child has a severe allergy to the substance listed on the front. (e.g. Reaction after ingestion, sting or exposure to allergen, allergy skin testing, etc.)

2. Describe your child's reaction. _____

3. Has the student ever experienced a life threatening reaction in the past that required emergency room care or hospitalization? _____

4. What care was needed at that time? _____

Parent/Guardian Consent for Unlicensed Personnel to Administer epinephrine auto-injector

I do / do not (check one) authorize Good Shepherd Episcopal School to designate unlicensed personnel who have been trained by a medical professional, including but not limited to, emergency medical personnel, a physician and/or a registered nurse to administer epinephrine auto-injector to my child while in attendance at Good Shepherd Episcopal School related events (such as field trips, athletic events and C.O.E.), when a trained medical professional may not be available. I understand that school related health services may not be provided to my student without my required consent, as outlined herein. Parent initials

Parent/Guardian Release of Claims Against Good Shepherd Episcopal School and Agreement to Indemnify

To the extent permitted under the law, on behalf of myself and the student, I release and agree to defend, indemnify, and hold harmless Good Shepherd Episcopal School for all claims, damages, demands, or actions arising from, relating to or growing out of, directly or indirectly, the administration of epinephrine auto-injector to the student of the epinephrine auto-injector. This release is to be construed as broadly as possible. It includes a release of claims against the Good Shepherd Episcopal School for its, joint or singular, sole or contributory, negligence or strict liability, including liability arising from the alleged violation of any statute (other than those which protect against discrimination based on race, age, sex, or other classification which has experienced historical discrimination), growing out of, relating to, or arising out of, directly or indirectly, the School Staff's administration of epinephrine auto-injector to the student, or the disclosure of the student's Individually Identifiable Health Information, including but not limited to claims that School Staff failed to properly and sufficiently assess my child's knowledge and ability to identify symptoms, negligently failed to recognize symptoms requiring the use of epinephrine auto-injector misconstrued symptoms which it believed necessitated the use of epinephrine auto-injector administered or failed to administer epinephrine auto-injector and/or "over-disclosed" my child's health information.

Parent's Name _____

Phone _____

Parent's Signature _____

Date _____