



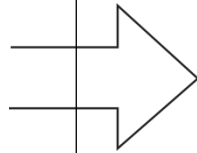
SPRING LAKE PARK SCHOOLS

GENERAL INFORMATION

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_
Emergency contact: \_\_\_\_\_ Phone number: \_\_\_\_\_
Provider: \_\_\_\_\_ Phone number: \_\_\_\_\_
Allergy to: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.
Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

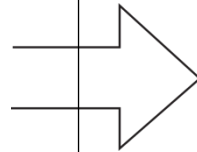
Extremely reactive to the following: \_\_\_\_\_

Any SEVERE SYMPTOMS after suspected or known contact:
One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body
Or combination of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, diarrhea, crampy pain



1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:
-Antihistamine
-Inhaler (bronchodilator) if asthma
\*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:
MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort



1. GIVE ANTIHISTAMINE
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

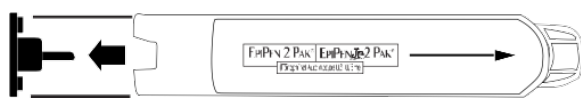
Epinephrine (brand and dose): \_\_\_\_\_
Antihistamine (brand and dose): \_\_\_\_\_
Other (e.g., inhaler-bronchodilator if asthmatic): \_\_\_\_\_
May Self-Carry Medication: [ ] Yes [ ] No

Monitoring

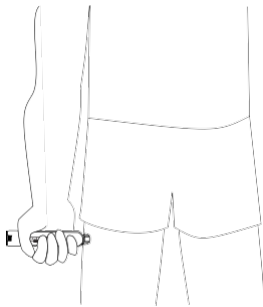
Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

**EpiPen Auto-Injector and EpiPen Jr  
Auto-Injector Directions**


First, remove the EpiPen Auto Injector from the carrying case  
Pull off the blue safety release cap



Hold orange tip near outer thigh (always apply to thigh)





Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 3 seconds. Remove the EpiPen Auto-Injector and massage the area for 3 seconds



DEY™ and the Dey logo, EpiPen™, EpiPen 2-Pak™, and EpiPen Jr 2-Pak™ are registered trademarks of Dey Pharma, L.P.

**Adrenaclick™ 0.3 mg and  
Adrenaclick™ 0.15 mg Directions**

Remove GREY caps labeled “1” and “2.”

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student’s physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

**Contacts**

Provider: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Other Emergency Contacts**

Name/Relationship: \_\_\_\_\_  
Name/Relationship: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Student Agreement:**

I agree to:

- Only self-carry Ibuprofen/Tylenol
- Follow my prescribing health professional’s medication orders
- Use correct medication administration techniques
- Maintain a written record of my medication administration at school
- Not allow anyone else to use my medication
- Keep a supply of my medication with me in school and on field trips
- Notify the school nurse or health office personnel if the following occurs:
  - My symptoms continue to get worse after taking the medication
  - My symptoms reoccur within 2-3 hours after taking the medication
  - I suspect that I am experiencing side effects from my medication
  - Other: \_\_\_\_\_
- I understand that permission for self-administration of medication may be suspended if I am unable to maintain the procedural safeguards established above.

\_\_\_\_\_  
**Signature of Student**

\_\_\_\_\_  
**Date**