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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: ❑Observe	❑Epinephrine	❑Antihistamine
If student has been exposed to food allergen: ❑Observe	❑Epinephrine	❑Antihistamine
Mouth: Itching, tingling or welling of lips, tongue, mouth	❑Epinephrine	❑Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremities	❑Epinephrine	❑Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	❑Epinephrine	❑Antihistamine
Throat*: Tightening of the throat, hoarseness, hacking cough	❑Epinephrine	❑Antihistamine
Lung*: Shortness of breath, repetitive cough, wheezing	❑Epinephrine	❑Antihistamine
Heart*: Weak, thready pulse, low blood pressure, fainting, pale blueness	❑Epinephrine	❑Antihistamine
Other*	❑Epinephrine	❑Antihistamine
If Reaction is progressing (several of the above areas affected), give:	❑Epinephrine	❑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_____

For Clinic Use Only:

_____Medication Received Date_____ ____Medication Returned Date_____