School Health Services
Allergy Action Plan

Place Child's Picture Here

Student Name: _____DOB: _____ Grade: _____

Allergy to: _____

Asthmatic No ☐ Yes* ☐ *High Risk for severe reaction

SIGNS OF AN ALLERGIC REACTION

- MOUTH itching and swelling of the lip, tongue, or mouth
- THROAT* itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- SKIN hives, itchy rash and/or swelling about the face or extremities
- GI nausea, abdominal cramps, vomiting, and/or diarrhea
- LUNG* shortness of breath, repetitive coughing, and/or wheezing
- HEART* "thread" pulse, "passing-out"

**All above symptoms can potentially progress to a life-threatening situation.*

ACTION FOR MINOR REACTION

1. If only symptoms are:_____,
   Give_____
2. Then call:
   Parent/Guardian: _____
   Parent/Guardian: _____

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION

1. If ingestion is suspected and/or symptom(s) are:_____
   _____give_____immediately
   Medication/Dose/Route
2. Then call:
   Parent/Guardian: _____
   Parent/Guardian: _____

EPIPEN DIRECTIONS

1. Pull off gray safety cap
2. Place BLACK TIP on OUTER THIGH
3. Push hard until you feel unit activate
4. Hold in place for 10 seconds, then remove and discard
5. Massage injection area for 10 seconds

Does your child wear a medic alert tag? Yes ☐ No ☐

Office Use Only: Plan review/renew dates _____ _____ _____ _____

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Self-Administration of EPINEPHRINE

Does child self-administer Epinephrine? ☐ Yes* ☐ No

If yes, student must:

- Understand circumstances/symptoms associated with their need for Epinephrine Pen
- Know proper technique of self administration of Epipen
- Agree NEVER to share Epipen with another person
- Agree to seek help immediately from nurse, teacher or adult

Note: Please provide required medications as soon as possible. All medications must be labeled with the student's name and accompanied by a written physician order or pharmacy label, and authorization for administration by the parent/guardian. Students are permitted to carry and self-administered Epipens if permission is on file with the nurse. Contact school nurse regarding this policy.

Parent/Guardian Signature: _____Date:_____

Transportation/Bus Ride: Necessary arrangements needed to and from school/on bus ride:

_____

_____

Field Trips: Necessary arrangements needed on field trips:

_____

_____

School Parties and Special Events: (Food Allergies only)

___ Child will consume ONLY the food and drink sent in by parent/guardian

___ Child may consume food pre-approved by parent*

*Teacher must obtain parent permission for snack to be approved

___ Child will self-monitor all food offered to him/her

___ Other: _____

Cafeteria: (Food Allergies Only)

Indicate any special arrangements necessary in cafeteria. Please be specific: _____

_____

_____

Other:

Please address any other issues, guidelines or special precautions that you feel are important to your child's safety and care during the school day. Please be specific: _____

_____

_____

My signature below indicates that I have completed the above information and agree with the recommended actions. I also authorize the release of this Allergy Action Plan to the employees of Hampton Township School District.

Parent/Guardian Signature: _____Date: _____

Physician Signature: _____ Date: _____