Allergy Action Plan

DEXTER COMMUNITY SCHOOLS

Name_____ **D.O.B**_____ **Grade**_____

****PLEASE NOTE: Healthcare provider to complete remainder of this page except parent signature****

Allergy to:_____

ACTION FOR MINOR REACTION

1. If only symptom(s) are: A few localized hives, mild itching, mild nausea give ANTIHISTAMINE. (see dose below)
2. Stay with student; call parents or emergency contacts.
3. Continue to observe child, if symptoms progress or fail to improve, follow steps for **MAJOR REACTION**.

SIGNS OF AN ALLERGIC REACTION

Systems/Symptoms

- MOUTH- Itching or swelling of the lips, tongue or mouth
- THROAT- Itchy throat, sensation of tightness, swelling, hoarseness, hacking cough
- SKIN- Diffuse hives, itchy rash, redness swelling about the face or extremities
- STOMACH- Nausea, abdominal cramps, vomiting, diarrhea
- LUNG- Shortness of breath, repetitive coughing, wheezing
- HEART- Weak pulse, passing out

*The severity of symptoms can quickly change. * All above symptoms can potentially progress to a life-threatening situation.*

ACTION FOR MAJOR REACTION

1. Inject epinephrine IMMEDIATELY in thigh.
2. Call 911 and request an ambulance with epinephrine. Inform them that you have given epinephrine.
3. Give antihistamine (IF NOT VOMITING) and inhaler if history of asthma.
4. Stay with child at all times.
5. Lay child flat and raise legs. If vomiting, allow them to lay on their side or sit up.
6. If symptoms fail to improve or return, give another dose of epinephrine 5 minutes after the first dose.
7. Call parents or emergency contacts.

MEDICATIONS/DOSES

Epinephrine Brand:_____ Epinephrine Dose: ☐ 0.3 mg ☐ 0.15 mg

Antihistamine Brand or Generic:_____ Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

The student is capable of ____self-administering ____self-possessing the above medication.

_____ _____

Physician/Healthcare Provider Signature Date

I give my permission to Dexter Community Schools to enter an emergency plan into PowerSchool and to distribute the plan to necessary school district staff and allow school staff to administer above medication as needed.

_____ _____

Parent/Guardian Signature Date

Adapted from University of Michigan Hospitals and Health Centers Food Allergy Action Plan Division of Allergy & Clinical Immunology rev. 4/2022