Peaster ISD

# Allergy Action Plan

Student Name _____ DOB _____

Parent/Guardian _____ Phone_____

_____ Phone_____

Is the student asthmatic? ☐ Yes ☐ No *if yes there is a higher risk for severe reaction*

***** ALLERGY TO _____*****

**All of the below information to be determined by a physician**

## Symptoms:

## Give the Checked Medication

- If known allergen has been ingested, but *no symptoms* ☐ EpiPen ☐ Antihistamine
- **MOUTH** - itching, tingling, or swelling of lips/tongue/mouth ☐ EpiPen ☐ Antihistamine
- **SKIN** – hives, itchy rash, pale, blue, swelling face/extremities ☐ EpiPen ☐ Antihistamine
- **GUT** – nausea, abdominal cramps, vomiting, diarrhea ☐ EpiPen ☐ Antihistamine
- **THROAT** – tightening of throat, hoarseness, hacking cough ☐ EpiPen ☐ Antihistamine
- **LUNG** – shortness of breath, coughing, wheezing ☐ EpiPen ☐ Antihistamine
- **HEART** – fast pulse, low blood pressure, fainting ☐ EpiPen ☐ Antihistamine
- **OTHER** - _____ ☐ EpiPen ☐ Antihistamine

## Medication Orders:

EpiPen EpiPen Jr. (circle one) May be injected intramuscularly as ordered.

Antihistamine Orders: _____

Other:_____

***** If EpiPen has been administered, CALL 911 and contact parent/guardian*****

**Authorization for Self Carry / Self Administration of Epinephrine**

In my professional opinion, the student should be allowed to carry the prescribed epinephrine injector on his/her person and self administer medication. I believe that the student is competent in his/her known allergy and is able to perform the medication administration technique properly.

_____ (Physician Initials)

I, the parent/guardian am requesting that my child be allowed to keep the prescribed epinephrine injector on his/her person at all times and be able to self administer medication as needed and as directed by the physician. I understand that it is the student's responsibility to keep the epinephrine injector on his/her person. If it is misplaced or used by other students, this privilege may be revoked. I also understand that it must have a proper prescription label.

_____ _____ (Parent Initials)

| |
|---|
| I give permission for the school nurse to consult with the above named physician, and obtain needed information regarding my child's health condition and medications as it pertains to my child's health and safety while at school. |

_____ _____

Physician Signature Date

_____ _____

Parent's Signature Date

_____ _____

Nurse's Signature Date

_____ _____

Nurse Aide Signature Date