# Allergy Action Plan

Student Name:_____ DOB:_____ Asthma: Y / N

List All Allergies:_____

**PARENT – PLEASE PROVIDE EPINEPHRINE AUTO-INJECTORS WHICH WILL NOT EXPIRE DURING THE SCHOOL YEAR**

I request that my child be allowed to take medication at school according to instruction from his physician. I understand it is my responsibility to bring the medication in the original pharmacy container labeled with student name, medication, dosage and directions (Ed Code 49423). I authorize school personnel to assist with this medication for my child as ordered by the physician. I understand trained, non-medical personnel may assist with or administer medication (Ed Code 49423 and 49480). I will notify the school of any changes in medication. I understand that the School Nurse may communicate with the Health Care Provider about this student when necessary.

_____ _____ _____

*Parent/Guardian Signature* *Date* *Phone*

**PHYSICIAN -- COMPLETE MEDICATION LIST BELOW AND *CHECK* ALL THAT APPLY**

☐ **Epinephrine Auto-Injector** _____ **CIRCLE DOSE: Epinephrine 0.15 mg Epinephrine 0.30 mg**

☐ A SECOND DOSE OF EPINEPHRINE MAY BE GIVEN 10-15 MINUTES AFTER THE FIRST DOSE, IF SYMPTOMS PERSIST OR RECUR

☐ ***Antihistamine:** _____ **Give by mouth DOSE:**_____

☐ ***Inhaler:** _____ **DOSE:** _____ **Puffs Every**_____**Hours**

☐ **If this box is checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms**

| SEVERE SYMPTOMS | ACTION |
|---|---|
| Any SEVERE SYMPTOMS after Suspected Ingestion/Exposure:<br>**ONE OR MORE OF THE FOLLOWING**<br>▪ LUNG: Difficulty Breathing, Audible Wheezing, Difficulty Talking<br>▪ HEART: Pale, Blue, Faint, Dizzy, Confused, Weak Pulse<br>▪ THROAT: Tight, Hoarse, Trouble Breathing / Swallowing<br>▪ MOUTH: Significant Swelling of Tongue and Lips<br>▪ SKIN: Many Hives over Body, Widespread Redness<br>▪ G.I.: Repetitive Vomiting or Severe Diarrhea<br>▪ OTHER: Feeling something bad is about to happen, anxiety, confusion<br>**OR a combination of mild or severe symptoms from different body areas** | **1. INJECT EPINEPHRINE IMMEDIATELY**<br>**2. CALL 911**<br>**3. BEGIN MONITORING (SEE BOX BELOW)**<br>**4. GIVE ADDITIONAL MEDICATIONS IF ORDERED ABOVE * .**<br><br>*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis).<br>**USE EPINEPHRINE** |

| MILD SYMPTOMS ONLY | ACTION |
|---|---|
| Any MILD SYMPTOMS only:<br>▪ MOUTH: Itchy Mouth<br>▪ NOSE: Itchy, Runny Nose, Sneezing<br>▪ SKIN: A Few Hives, Mild Itch<br>▪ G.I.: Mild Nausea, Discomfort | **1. GIVE ANTIHISTAMINE, IF ORDERED ABOVE**<br>2. Stay With Student. Alert Office and Parent/Emergency Contacts<br>**3. IF SYMPTOMS BECOME SEVERE, SEE ABOVE, USE EPINEPHRINE AND CALL 911**<br>4. Begin Monitoring (see box below) |

**MONITORING**

1. Stay with student
2. Tell paramedic Epinephrine was given, **note time**. If a second dose is given, **note time**.
3. For a severe reaction: **KEEP STUDENT HORIZONTAL -- LEGS RAISED -- TURN ON SIDE IF NAUSEOUS**
4. A second dose of Epinephrine may be given 10-15 minutes after the first dose, if checked above.
5. **If breathing stops at any time during the procedure initiate CPR immediately.**

☐ **Student to carry medication and self-administer.** The health care provider has confirmed that the student is capable of appropriate self-administration of the above medication. If student is younger than 18, the parent/guardian assumes all liability related to this patient's use, timing and technique in self-administering this medication.

Physician Signature:_____ Date:_____

**Student Contract for Carrying Own Medication:** I will be responsible for carrying, administering, and keeping my medication safe at all times. I will use the medication in the way prescribed by my physician. I will not show or share my medication with other students. I will immediately report to persons in charge if my medication is missing. Signed: _____

Clinic Stamp