Anaphylaxis Allergy Action Plan

[Student Photo]

Student Name: _____ DOB:_____ Age: _____ Wt:_____

School Year: _____ Grade: _____ Teacher/Team: _____

This student may experience a life-threatening allergic reaction to:

Does this student have an asthma diagnosis? Yes___ No____ *If yes, this student may be at a higher risk for a more severe reaction to the above allergen.

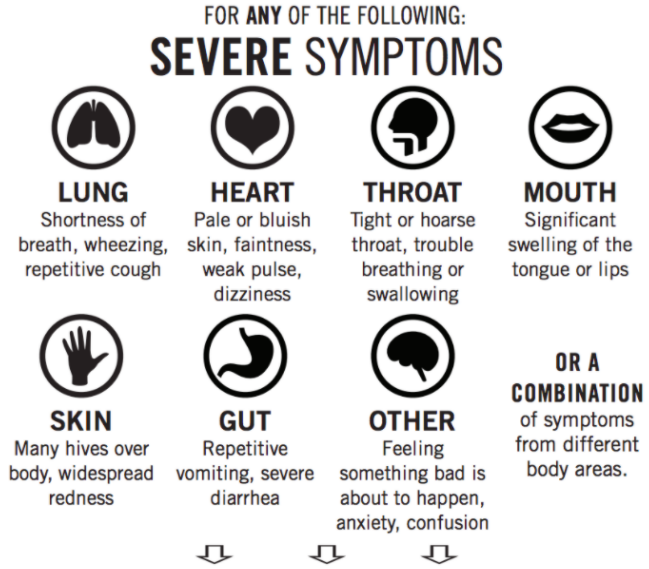
Standard Classroom Precautions:

- ❏ Allergen discussion
- ❏ Encourage no food sharing
- ❏ Nut-free sign outside of classroom

Optional Parent-Requested Precautions (check all that apply):

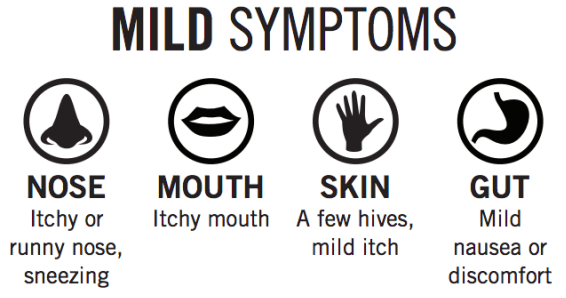
- ❏ Nut-Free lunch table
- ❏ No allergens in classroom (nuts only)
- ❏ Clean student desk before/after food-related activities

Severe Reaction: Epinephrine auto-injector



1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

Mild reaction or in addition to Epinephrine:



FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

Medication:_____ ❏ Dose: ❏ 0.3mg (> 30 kg or 66 lbs) ❏ 0.15mg (15 to 30 kg or 33 to 66 lbs) **Directions**: Give above dose intramuscularly, call 911. **Additional instructions:**	❏ **Antihistamine** ❏ Medication:_____ ❏ Dose:_____ ❏ Frequency: _____ ❏ Route:_____ ❏ **Inhaler/Bronchodilator** ❏ Medication:_____ ❏ Dose: _____ ❏ Frequency: _____ ❏ Route: inhalent_____
Medication Storage Location ❏ Clinic/office ❏ Self-carry (see permission to self-carry)	**Medication Storage Location:** ❏ Clinic/office

I request that the above medication be administered to my child as directed by the Anaphylaxis Allergy Action Plan. I give Delaware City Schools and its staff permission to speak with my physician regarding the above named diagnosis and administration of medications to my child.

Medical Provider Signature: _____Date:_____

Provider Print Name: _____ Phone: _____ Fax: _____

Parent Signature:_____ Date:_____

Parent Print Name: _____

Permission to Self-Carry and/or Self-Administer Epinephrine Auto-Injector

As the parent/guardian of the above named child, I give my permission to allow the following to occur:
- ❏ Self-Carry Epinephrine Auto-Injector
- ❏ Self-Administer Epinephrine Auto-Injector

My child's healthcare provider is in agreement that the above-named child is aware of their allergens and is deemed capable of determining the appropriate course of action should a reaction occur while in school. The school building nurse or staff member will be notified immediately should the medication be given as the emergency protocols must still be followed. The child has been adequately trained and is aware of the expectations associated with this responsibility. The child understands that their prescription medication is to be used only on themselves and never for another student.

Parent Signature: _____ Date:_____

Provider Signature:_____ Date:_____

For DCS staff use only:	
___ Copy of AAAP in clinic ___ Copy of AAAP to teacher(s) ___ Staff medication training	___ Nut letter sent home to students (elementary only) ___ Nut-free zone sign outside classroom (elementary only) ___ Notify cafeteria staff

Student Name: _____