ROCKWALL ISD
HEALTH SERVICES
HEALTHY CHILDREN, BETTER STUDENTS, HEALTHY COMMUNITIES

Allergy/Anaphylaxis Action Plan

Student Photo

Student name _____ **D.O.B.** _____ **Teacher/grade** _____

Healthcare Provider _____ **Preferred Hospital** _____

ALLERGY: (check appropriate) **To be completed by Health Care Provider**

☐ History of Asthma *(increased risk for severe reaction)*
☐ Insects (list):
☐ Foods (list):
☐ Latex (circle): Type I (anaphylaxis) Type IV (contact dermatitis)
☐ Medications (list):
☐ Other (list/describe):

Any SEVERE SYMPTOMS or more than one MILD SYMPTOM:
LUNG: short of breath, wheeze, cough
HEART: Pale, blue, weak pulse, dizzy, passing out
THROAT: itching, tightness/closure, hoarseness
MOUTH: Itching, swelling of lips and/or tongue
SKIN: Many hives over body, widespread redness
GUT: Vomiting, diarrhea, cramps
OTHER: anxiety, confusion, feeling of dread/something bad is about to happen

1. **INJECT EPINEPRHINE IMMEDIATELY**
2. **Call 911**
3. Place in supine position or seated upright position and monitor closely
4. Give additional medications
   --Inhaler (bronchodilator) if asthma
   --antihistamine
5. Repeat Epinephrine in 5 to 15 minutes if symptoms persist/worsen

*Antihistamines & inhalers are not to be depended upon to treat a severe reaction. USE EPINEPHRINE.

ONE MILD SYMPTOM (involvement of only one system with NO respiratory or cardiovascular symptoms)
MOUTH: Itchy mouth
NOSE: Itchy/runny nose, sneezing
SKIN: A few hives or localized redness; mild itch

1. Stay with student; monitor closely
2. If symptoms progress USE EPINEPHRINE (see above)
3. If no progression of symptoms administer antihistamine

MEDICATION

Epinephrine: ☐ EpiPen 0.3mg ☐ EpiPen Jr. 0.15mg ☐ Auvi-Q 0.3mg ☐ Auvi-Q 0.15mg
☐ Other/generic epinephrine (specify): _____

Inhaler/bronchodilator: _____
(brand/drug) (dose/frequency)

Antihistamine:

☐ mild/one symptom after _____ minutes observation _____
(brand/drug) (dose/frequency)

☐ severe reaction, following epinephrine, if able to swallow _____
(brand/drug) (dose)

☐ other (specify): _____

SELF-ADMINISTRATION

☐ This child has received instruction in the proper use of their epinephrine auto-injector. The child has been advised to inform a responsible adult if epinephrine is self-administered. It is my professional opinion that this student **SHOULD** be allowed to carry and use their epinephrine auto-injector independently.

☐ It is my professional opinion that this student **SHOULD NOT** carry their epinephrine auto-injector.

Provider Print/Stamp _____ **Signature:** _____ **Phone:** _____ **Date:** _____

Student/Parent/Guardian Agreement (check boxes to indicate agreement):

☐ I have been trained in the use of my EpiPen (or other auto-injector epinephrine) and prescribed allergy medication and understand the signs and symptoms for which they are to be given.

☐ I know it is my responsibility to keep my medication with me so that it is easily accessible in case of an emergency during school hours, extracurricular activities and field trips.

☐ I will notify a responsible adult (teacher, nurse, coach, etc.) **IMMEDIATELY** when EpiPen is used.

☐ I will not share my medication, leave my EpiPen unattended, or use my medications for any other use that for which it is prescribed.

☐ I will inform the school nurse and my parents if my medication is lost, stolen, or has expired.

☐ I would like for my classmates and/or their parents to be aware of my food allergy.

Before/after school programs/extracurricular activities: ☐ ROCK ☐ Athletics ☐Band ☐ Drill Team ☐Cheer ☐Other (list): _____

How does your child get home? ☐Parent/Daycare pick-up ☐Walk ☐Bus#_____

***Elementary students**:* I would like for my child to sit in a Peanut/Nut/Allergen-Aware Zone in the cafeteria. ☐Yes ☐No

It is recommended that backup medication be stored with the school/ school nurse in case a student forgets or loses their EpiPen. The school district is not responsible or liable if backup medication is not provided to the school/ school nurse and student is without working medication when medication is needed.

Your signature gives permission for the nurse to implement this action plan and to contact and receive additional information from your healthcare provider regarding the allergic condition(s) and the prescribed medication. Anaphylaxis Action Plan will be shared with school personnel with legitimate educational interest.

Parent/Guardian Signature: _____Phone: _____ Date_____

Student Signature (if self-administering):_____Backup medication stored at school? ☐ Yes ☐No

PREVENTION: Avoidance of allergen is crucial to prevent anaphylaxis. Critical components to prevent life threatening reaction: Initial boxes to indicate activity completed by school staff.

	Encourage the use of Medic-alert bracelets
	Notify nurse, teacher(s), front office and kitchen staff of known allergies (include substitutes)
	Avoid use of latex-containing products in schools (balloons, gloves, etc.)
	Consider food and safety provisions while off campus (field trips)
	Discourage allergen-containing snacks
	Encourage allergen aware zone(s) in the school cafeteria
	Other:

DIRECTIONS FOR EPIPEN® AND INITIAL TWINJECT® USE

1. Remove activation cap(s) (blue or green).
2. Hold auto-injector tip (orange or red) to outer thigh (apply to thigh **only**).
3. Press hard into outer thigh until auto-injector mechanism functions. Hold in place for 10 seconds.
4. Massage the injection site for 10 seconds.
5. **Call 911/EMS**.

STAFF MEMBERS TRAINED *Skills training checklists completed by nurse and on file in clinic*

Name	Name	Name

EMERGENCY CONTACTS

	Name	Home #	Work #	Cell #
Parent/Guardian				
Parent/Guardian				
Other:				
Other:				

Approved by Nurse/Principal Signature: _____ Date: _____