

Place
Child's
Picture
Here



Academy of Accelerated Learning, Inc.

Allergy Action Plan

Transportation
 Car Rider Walker
 Bus # _____
 Other: _____

Student has permission to transport medication listed below to and from school?
 YES NO

Students Name		Date of Birth	Grade
Parent/Guardian	Phone		Cell
Other Emergency Contact	Phone		Cell
Allergy to:		Triggers:	

Asthma: Yes No *Higher risk for severe reaction

Sensitivity: Ingestion Only Topical/Ingestion Topical Airborne

Additional Details:	Yes	No	Comments
History of EpiPen use			
History of reaction			
Special lunch seating required			
Classroom accommodation needed			

STEP 1: TREATMENT

<u>Symptoms:</u>		<u>Give Checked Medication**:</u> <small>** (To be determined by physician)</small>	
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Throat†	Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Lung†	Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Heart†	Weak or thready pulse, low blood pressure, fainting, pale,	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
• Other†	_____	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
•	If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

	Name of Medication	Dose	Route
Antihistamine			
Epinephrine			
Other			
Other			

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: ANAPHYLACTIC EMERGENCY PROTOCOL

- Contact campus nurse at _____
- Administer emergency medications
- Call 911
- Notify parent or emergency contact
- Document episode/Student Accident Report Filed & complete Post Anaphylaxis Reaction Review
- Other: _____

I agree with the recommendations of my child's HCP and authorize AAL staff to deliver treatment as outlined above. I also give permission for my child's HCP to communicate with appropriate AAL employees for the current school year.

Physician Name	Printed Name	Phone	Date
Parent/Guardian Signature		Date	

ADDENDUM to Action Plan

NURSE USE ONLY:

- Transportation Notified: Date Faxed _____
- Bus Driver Notified
- Added to Medical Alerts
- Self-Carry
- Diet Modification: Date Faxed _____
- RTI 504 ARD Committee Notified: Date _____

In addition: A full IHP needed for a 504 or an ARD

	Field Trips	Student will be grouped with a trained staff member.
	Before or After School Activities (i.e. Safety Patrol, Clubs, Sports)	Nurse and Parent will discuss a plan for their child.
	Emergency Evacuation of School	Nurse will bring medication/supplies out of building and will attend to student as needed.

◇ TRAINED STAFF MEMBERS ◇

(To be completed by campus personnel)

Teacher's Name:	Date:
Teacher's Name:	Date:
Administrator's Name:	Date:
Office Staff's Name:	Date:
Cafeteria Staff's Name:	Date:
Bus Driver's Name:	Date:
Other Name:	Date:
Other Name:	Date:
Other Name:	Date:

OTHER COMMENTS:

Nurse Signature: _____

Date: _____