ALLERGY/ANAPHYLAXIS Action PLAN

Student Name ____________________ **D.O.B.** ________ **Teacher** _____________
School Nurse_____________________________ **Phone Number** __________________
Health Care Provider ___________________ **Preferred Hospital** _________________
History of Asthma No Yes (Higher risk for severe reaction)

ALLERGY: (check appropriate) **TO BE COMPLETED BY HEALTH CARE PROVIDER *ONLY***
Foods (list):___________________________ **Medications (list) :**____________________
Latex: ***Circle***: **Type I (anaphylaxis) Type IV (contact dermatitis)**
Stinging Insects (list): _______________________ **Other (list):**_____________________

RECOGNITION AND TREATMENT:* To be completed by Health Care Provider *ONLY			**Give CHECKED Medication**	
If food ingested or contact with allergen occurs:			Epinephrine	Antihistamine
No symptoms noted	Observe for other symptoms			
Mouth	Itching, tingling, or swelling of lips, tongue, mouth			
Skin	Hives, itchy rash, swelling of the face or extremities			
Gut**+**	Nausea, abdominal cramps, vomiting, diarrhea			
Throat**+**	Tightening of throat, hoarseness, hacking cough			
Lung**+**	Shortness of breath, repetitive coughing, wheezing			
Heart**+**	Thready pulse, low BP, fainting, pale, blueness			
Neuro**+**	Disorientation, dizziness, loss of consciousness			
If reaction is progressing (several of the above areas affected), **GIVE:**				

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

DOSAGE: **TO BE COMPLETED BY HEALTH CARE PROVIDER *ONLY***

· **Epinephrine:** Inject into outer thigh **0.3 mg** ___OR **0.15 mg**___

· **Antihistamine: Diphenhydramine (Benadryl®)** _______mg (Liquid or Fastmelts). ONLY *if able to swallow.*

· **Epinephrine Auto Injector will be used for a severe asthma episode at school, this may be given in addition to the student's prescribed medication or if the student does not have access to their prescribed medication.**

__ This child has received instruction in the proper use of the EpiPen®. It is my professional opinion that this student **SHOULD** be allowed to carry and use the EpiPen independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the EpiPen is self-administered.

____It is my professional opinion that this student **SHOULD NOT** carry the EpiPen. :

Health Care Provider Signature ____________________ Phone: ______________ Date _________

CSD EMERGENCY PROTOCOL:

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call parents/guardian to notify of reaction, treatment and student's health status.
3. Treat for shock. Prepare to do CPR.

To Be Completed by Parent/Guardian

PARENT/GUARDIAN AUTHORIZATIONS:

□ I want this allergy plan implemented for my child; **I want my child to carry the EpiPen** and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of the EpiPen.

□ I want this plan implemented for my child and I **do not** want my child to self-administer epinephrine.

□ Parent is responsible for EpiPens for before and after school activities (there is no nurse available).

_ It is recommended that backup medication be stored with the school/ school nurse in case a student forgets or loses EpiPen and/or antihistamine. 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.

EMERGENCY CONTACTS:

	NAME	HOME #	WORK #	CELL #
PARENT/GUARDIAN				
PARENT/GUARDIAN				
OTHER:				

Your signature gives permission for the nurse to contact and receive additional information from your health care provider regarding the allergic conditions) and the prescribed medication.

Parent/Guardian Signature: _________________________ Phone: ______________ Date: _________

***STUDENT AGREEMENT*:**

□ I have been trained in the use of my EpiPen and allergy medication and understand the signs and symptoms for which they are given;

□ I agree to carry my EpiPen with me at all times;

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

□ I will not share my medication with other students or leave my EpiPen unattended;

□ I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature: ____________________________________ **Date** ________________

Approved by Nurse, Signature: ______________________________ **Date** ____________________

STAFF MEMBERS TRAINED:

NAME	TITLE	LOCATION/ROOM	TRAINED BY (RN only)

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Form adapted from the Food Allergy Anaphylaxis Network, "Food Allergy Action Plan" & the Asthma and Allergy Foundation of America, Alaska Chapter