Petal School District
Allergy Action Plan

Student Photo

Student Name:_____ Date of Birth:_____
School:_____ Phone:_____ Fax:_____
Health Care Provider:_____ Preferred Hospital:_____

PHYSICIAN PAGE: *(to be completed by health care provider ONLY)*

ALLERGY:

☐ **Foods:** *(list)*_____
☐**Medications:**
*(list)*_____
☐**Latex:** ☐**Type I (anaphylaxis)** ☐**Type IV (contact dermatitis)**
☐**Stinging Insects:** *(list)*_____
☐**Other:** *(list)*_____

RECOGNITION AND TREATMENT:		**Give checked medication**	
If food is ingested or contact with allergen occurs:		Epinephrine	Antihistamine
No symptoms noted	❒Observe for symptoms		
Mouth	Itching, tingling, swelling or lips, tongue, or mouth		
Skin	Hives, itchy rash, swelling of 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 are affected, Give:			
The severity of symptoms can quickly change ***+ Potentially life threatening***			

Emergency Protocol

1. **Call 911.**
   State that an allergic reaction has been treated and additional epinephrine may be needed. Follow 911 instructions.
2. **Call parents/guardian.**
   Notify of reaction, treatment, and student health status
3. **Treat for Shock.**
   If becomes unresponsive or stops breathing,, start CPR.

DOSAGE:

- Epinephrine: inject outer thigh ❒0.3mg ❒0.15 mg
- Antihistamine: Diphenhydramine (Benadryl) _____mg (liquid or fastmelts). ONLY IF ABLE TO SWALLOW
- Other:_____

❒ This child has received instruction in the proper use of their prescribed epinephrine injector. It is my professional option that this student **SHOULD** be allowed to carry and use the auto-injector and antihistamine independently. The child knows when to request antihistamine and has been advised to inform a responsible adult when the auto-injector is self-administered.
❒ It is my professional opinion that this student **SHOULD NOT** carry the auto injector.
❒ This child has special needs and the following instructions apply:_____

Health Care Provider Signature: _____ Date:_____

Health Name:_____
Received by:_____ Date:_____

Clinic Name and Phone Number:_____

Student Name:_____ Date of Birth:_____

PARENT/GUARDIAN PAGE: *(to be completed by parent)*

AUTHORIZATIONS:

❒ I want this allergy action plan implemented for my child. **I want my child to carry their prescribed auto-injector.** ***In the event of self administration of epinephrine medication, the parent releases the school district and its employees from liability for an injury arising from the student's self administration of the prescription medication while on school property or school-related activities.***

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

❒ Parent is responsible for auto-injectors before and after school activities. (no nurse available)

The school nurse or principal's designee has my permission to administer epinephrine and antihistamine medication to my child as ordered by the physician. I understand that this Allergy Action Plan is only good for the current school year. I consent to the exchange of information between the physician/nurse practitioner and the school nurse regarding this medication and treatment.

Parent/Guardian Signature:_____Phone:_____ Date:_____

Emergency Contacts			
	Name	Phone #	Phone #
Parent/Guardian			
Parent/Guardian			
Other:			
Other:			

Student Agreement:

❒ I have been trained in the use of my auto-injector and allergy medication and understand the signs and symptoms for which they are given;

❒ I agree to carry my auto-injector with me at all times;

❒ I will notify a responsible adult (teacher, nurse, coach, etc) IMMEDIATELY when my autoinjector (epinephrine) is used;

❒ I will not share my medication with other students or leave my autoinjector unattended;

❒ I will not use my allergy medication for any other use than what it is prescribed for.

Student Signature:_____ Date:_____

Approved by Nurse: _____ Date:_____

Name	Trained By (RN only)	Date