PITTSBURGH PUBLIC SCHOOLS – HEALTH SERVICES

ANAPHYLACTIC ALLERGY ACTION PLAN

Enter School Year_____   **Enter Current Date**_____

LAST NAME			DOB		
FIRST NAME			GENDER: Male ☐	Female ☐	Non-Binary ☐
SCHOOL	GR	TEACHER			

ANAPHYLACTIC ALLERGY TO:_____

Y ☐	N ☐	Student is responsible to carry the EpiPen with them during the school day.
Y ☐	N ☐	The EpiPen will be kept with the nurse or office for immediate retrieval.

Medically necessary classroom or lunchroom accommodations? Yes ☐ or No ☐ If yes, please explain.

_____

_____

STEP 1: TREATMENT

Symptom: The severity of symptoms can quickly change.

Give checked emergency medication or specify treatment

Symptom	EpiPen		Other
If a food allergen has been ingested, but no symptoms	☐ EpiPen	☐	Benadryl
If stung by insect, with or without symptoms	☐ EpiPen	☐	Benadryl
Skin- Hives, itchy rash, swelling of face or extremities	☐ EpiPen	☐	Benadryl
Mouth- itching, tingling, or swelling of lips or tongue	☐ EpiPen	☐	Benadryl
Gut- Nausea, belly cramps, sudden vomiting or diarrhea	☐ EpiPen	☐	
Throat- Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐	
Lung- Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐	
Heart- Thready pulse, fainting, pale, blueness, low BP	☐ EpiPen	☐	
Other-	☐ EpiPen	☐	

DOSAGE

Epinephrine: inject intramuscularly (check one)   EpiPen ☐ or EpiPen Jr. ☐

This is an emergency medication and should be administered IMMEDIATELY BY STUDENT OR DESIGNATED SCHOOL STAFF.

Benadryl: give _____ tsp or _____ tab(s) by mouth if student is able to swallow.

Other: (Albuterol inhaler etc.)_____

These medications will be administered by the nurse or student. The nurse should be called to return to the building if not present.

STEP 2: CALL EMS if a severe allergic reaction is occurring or EpiPen is used.

1. Call 911, state that an allergic reaction has been treated, and additional support is needed.
2. Emergency Contacts: Call the parent/guardian to notify them of the incident.

Name & Relationship _____   **Phone** _____

Name & Relationship _____   **Phone** _____

I agree with the above plan, and agree that school health personnel and my child's physician or staff may discuss this plan if there are questions.

✘_____   ✘_____   ✘_____

PARENT/GUARDIAN SIGNATURE   PRINT NAME   DATE

PHYSICIAN SIGNATURE _____   PHYSICIAN PRINT NAME _____

DATE _____   PHONE _____   FAX _____