Allergy Action Plan

Name:_____ **D.O.B.**_____ **Weight**_____

Place student photo here

Allergy to: _____
History of Anaphylaxis? ☐YES ☐No type of reaction_____
Asthma: ☐Yes (higher risk for a severe reaction) ☐No

Extremely reactive to the following:_____
THEREFORE:
☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted

Any SEVERE SYMPTOMS after suspected or known ingestion/exposure:

One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, crampy pain

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Begin monitoring (see care plan)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.
Delegate may not administer inhaler or antihistamine

MILD SYMPTOMS ONLY:
MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Monitor student (see care plan)

Medications/Doses

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg
May Repeat x_____ every_____minutes. (In the absence of a school nurse a trained delegate may give epinephrine only for a multisystem reaction. Delegates may not administer antihistamine or asthma medications.)
Antihistamine: Give Diphenhydramine PO ___ 12.5 mg ___25 mg ___50mg _____ Other
Other (inhaler/bronchodilator if asthmatic):_____

TREAT STUDENT EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!
Doctor's Signature_____ **Date**_____ **Office Stamp**

I hereby request that the school nurse administer the above medication as directed by my physician to my child. I will supply medication in the ORIGINAL CONTAINER and will notify the school nurse promptly of any change in this order. As per policy, two Epi-pens or Twinjects are required.

Parent/Guardian Signature_____ Date_____

(Parent: please read all attached pages regarding delegation.
See School Nurse for Individual Healthcare Plan Review)