# ALLERGY/ANAPHYLAXIS ACTION PLAN

Student Photo

**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**

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

RECOGNITION AND TREATMENT

| **Chart to be completed by Health Care Provider ONLY** | | **Give CHECKED Medication** | |
|---|---|---|---|
| *If food ingested or contact w/ allergen occurs:* | | EpiPen | 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 conscience | | |
| If reaction is progressing (several of the above areas affected), GIVE: | | | |
| ***The severity of symptoms can quickly change. +Potentially life-threatening.*** | | | |

**DOSAGE:**

**Epinephrine:** Inject into outer thigh ☐ **EpiPen 0.3 mg** OR ☐ **EpiPen Jr. 0.15 mg** (see reverse for instructions)
**Antihistamine: Benadryl** _____mg To be given by mouth o*nly if able to swallow.*
**Other:**

☐ 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 _____

EMERGENCY CALLS

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.
4. Accompany student to ER if no parent/guardians are available.

PREVENTION: Avoidance of allergen is crucial to prevent anaphylaxis. Critical components to prevent life threatening reactions: ☑ Indicates activity completed by school staff

| | |
|---|---|
| | Encourage the use of Medic-alert bracelets |
| | Notify nurse, teacher(s), front office and kitchen staff of known allergies |
| | Use non-latex gloves and eliminate powdered latex gloves in schools |
| | Ask parents to provide non-latex personal supplies for latex allergic students |
| | Post "Latex reduced environment" sign at entrance of building |
| | Encourage a no-peanut zone in the school cafeteria |
| | Other: |

Rev. 08/05

*This form is adapted from The Food Allergy Anaphylaxis Network, "Food Allergy Action Plan" by the Alaska Asthma Coalition.*

## Side 2: To Be Completed by Parent/Guardian, Student and School

**Allergy/Anaphylaxis Action Plan** *(continued)* **Student Name** _____ **D.O.B.** _____

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

**Your signature gives permission for the nurse to contact and receive additional information from your health care provider regarding the allergic condition(s) 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, noon duty, etc.) **IMMEDIATELY** when auto-injector 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** _____

☐ Back-up medication is stored at school ☐ Yes ☐ No

**Approved by Nurse/Principal Signature:** _____ **Date** _____

### DIRECTIONS FOR EPIPEN® USE

1. Pull off gray activation cap.
2. Hold black tip to outer thigh (apply to thigh **only**).
3. Press hard into outer thigh until auto-injector mechanism functions. Hold in place for 10 seconds.
4. Massage the injection site for 10 seconds.
5. Once Epipen® is used, call 911/EMS. Take the used EpiPen to the emergency room with you.

### STAFF MEMBERS TRAINED

| Name | Title | Location/Room # | Trained By |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

### EMERGENCY CONTACTS

| | Name | Home # | Work # | Cell # |
|---|---|---|---|---|
| Parent/Guardian | | | | |
| Parent/Guardian | | | | |
| Other: | | | | |
| Other: | | | | |



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