

ALLERGY ACTION PLAN

Place
Child's
Picture
Here

Student's Name: _____ DOB: _____

School: _____ Teacher/Grade: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction, complete asthma action plan)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Please Check the Appropriate Allergen(s):

- | | | | |
|---|--------------------------------|---|---|
| ☐ Bee/Insect Stings | ☐ Eggs | ☐ Dairy | ☐ Peanuts |
| ☐ Latex | ☐ Soy | ☐ Shellfish | ☐ Tree Nuts (almonds, pecans, walnuts, etc.) |
| ☐ Allow food "processed in a facility with" allergen | ☐ Wheat | ☐ Other Food(s): _____ | |
| ☐ Allow food "made on shared equipment" as allergen | | ☐ Allow food that "may contain" allergen | |

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS

 LUNG Shortness of breath, wheezing, repetitive cough	 HEART Pale or bluish skin, faintness, weak pulse, dizziness	 THROAT Tight or hoarse throat, trouble breathing or swallowing	 MOUTH Significant swelling of the tongue or lips
 SKIN Many hives over body, widespread redness	 GUT Repetitive vomiting, severe diarrhea	 OTHER Feeling something bad is about to happen, anxiety, confusion	OR A COMBINATION of symptoms from different body areas.

- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

 NOSE Itchy or runny nose, sneezing	 MOUTH Itchy mouth	 SKIN A few hives, mild itch	 GUT Mild nausea or discomfort
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FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

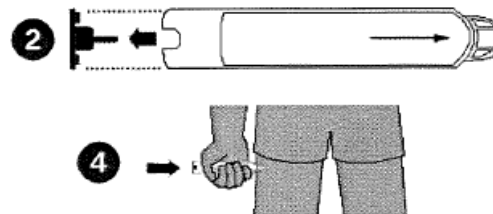
Antihistamine Brand or Generic: _____

Antihistamine Dose: _____ mg

Other (e.g., inhaler-bronchodilator if wheezing): _____

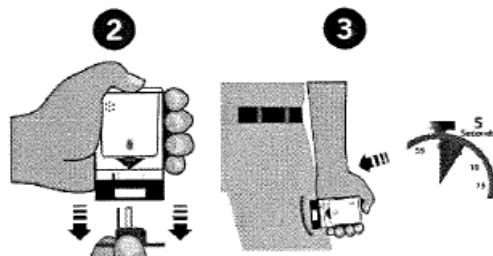
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENALCLICK®/ADRENALCLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



Additional Allergy Comments/Instructions:

IF YOU INJECT EPINEPHRINE, CALL 911 AND PARENTS.

Parent/Guardian: _____ Phone: _____

Emergency Contact: _____ Phone: _____

☐ **Yes** ☐ **No** This student has been trained in the use of the medication(s) above and he/she may carry and self-administer if needed, for life threatening allergic reaction.

ALLERGY CARE PROVIDER SIGNATURE

PLEASE PRINT PROVIDER NAME

DATE

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

PARENT SIGNATURE

DATE