Swallow School District

Allergy Action Plan

Student Name: _____ Birthdate: _____

Part 1: TO BE COMPLETED BY MEDICAL PROVIDER

Allergy to: _____

Student has Asthma: Yes___ or No___ Student has had Anaphylaxis: Yes___ or No___

Medication:	**Route:**	**Dose:**
Epinephrine auto-injector	IM	
Antihistamine:	Oral	
Inhaler:	Inhaled	

For SEVERE Allergy and ANAPHYLAXIS  **What to look for:** If student has ANY of these symptoms after eating the food/insect sting, **give epinephrine** • LUNG: shortness of breath, wheezing, repetitive coughing • HEART: pale or bluish skin, weak pulse, dizziness • THROAT: tight or hoarse, 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 of "doom," anxiety, confusion **___SPECIAL SITUATION**: If this is checked, the student has an extremely severe allergy to an insect or the following foods:_____. Even if the student has MILD symptoms, **give epinephrine immediately**.	**Give epinephrine now!** **What to do** 1. Stay calm! Inject epinephrine right away! Note time when epinephrine was given. 2. Call 911. 3. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine 4. Stay with student and: • Keep student still and calm • Call parents • Give second dose of epinephrine if symptoms get worse, continue, or do not get better in 5 minutes
For MILD Allergic Reaction  **What to look for** If child has any mild symptoms, **monitor child**. Symptoms may include: • Itchy or runny nose, sneezing • Itchy mouth • A few hives • Mild stomach ache, nausea, or discomfort	**Monitor Child** **What to do** 1. Stay calm and watch student closely 2. Give antihistamine (if prescribed) 3. Call parents 4. If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, give epinephrine.

Practitioner Printed Name: _____ Phone: _____

Clinic/Healthcare System: _____ Fax: _____

Practitioner Signature: _____ Date: _____

Part 2: TO BE COMPLETED BY PARENT/GUARDIAN

I give consent for school personnel to administer prescribed medication as directed by the medical provider as described above (part 1). I authorize communication between the prescribing health care provider, the school nurse, and trained school personnel necessary for the management and administration of this medication.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Contact Numbers: _____ _____ _____