

Allergy & Anaphylaxis Action Plan

Student's Name: _____ D.O.B. _____ Grade: _____
 School: _____ Teacher: _____

Place child's
photo here

ALLERGY TO: _____

History: _____

Asthma: ☐ YES (Higher risk for severe reaction) ☐ NO

◇ STEP 1: TREATMENT ◇

SYMPTOMS:

GIVE CHECKED MEDICATION(S)

➤ Suspected ingestion or sting, but <i>no symptoms</i>	☐ Epinephrine	☐ Antihistamine
MILD SYMPTOMS: Itchy mouth, few hives, mild itch, mild nausea/discomfort		☐ Antihistamine
MOUTH Itching, tingling, or mild swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
SKIN: Flushing, hives, itchy rash	☐ Epinephrine	☐ Antihistamine
STOMACH Nausea, abdominal pain or cramping, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
‡ THROAT Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
‡ LUNG Shortness of breath, repetitive coughing, wheezing ☐ Inhaler	☐ Epinephrine	☐ Antihistamine
‡ HEART Weak or thready pulse, dizziness, fainting, pale, or blue hue to skin	☐ Epinephrine	☐ Antihistamine
➤ If reaction is progressing (several of the above areas affected), give	☐ Epinephrine	☐ Antihistamine

‡ Potentially life threatening: give epinephrine first, then can give antihistamine!

Remember - severity of symptoms can quickly change!

DOSAGE

Epinephrine: inject intramuscularly using autoinjector (check one): ☐ 0.3 mg ☐ 0.15 mg

☐ Administer 2nd dose if symptoms do not improve in 15 – 20 minutes

Antihistamine: give _____
 (medication/dose/route)

Asthma Rescue (if asthmatic): give _____
 (medication/dose/route)

Student has been instructed and is capable of self administering own medication. ☐ Yes ☐ No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

◇ STEP 2: EMERGENCY CALLS ◇

1. If epinephrine given, **call 911**. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.

2. Parent: _____ Phone Number: _____

3. Emergency contacts: Name/Relationship _____ Phone Number(s) _____

a. _____ 1) _____ 2) _____

b. _____ 1) _____ 2) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

To be completed by healthcare provider

Student Name: _____ DOB: _____

TRAINED STAFF MEMBERS

1. _____
2. _____
3. _____
4. _____
5. _____

Room _____
Room _____
Room _____
Room _____
Room _____

Self-carry contract on file. ☐ Yes ☐ No

Medication located in: _____

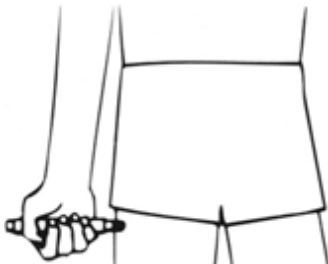
EpiPen® and EpiPen® Jr. Directions

Expiration date: _____

- Pull off blue activation cap.



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Expiration date: _____

- Remove caps labeled "1" and "2."

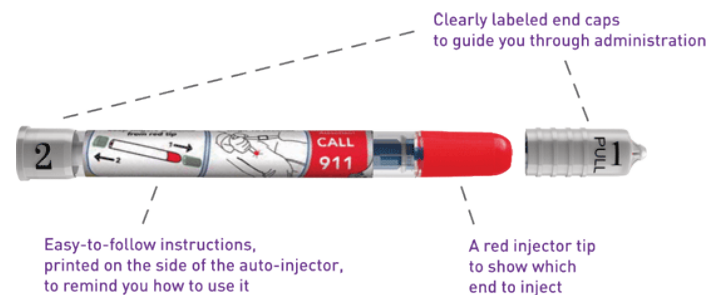


- Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.



Adrenaclick 0.3 mg. and Adrenaclick 0.15 mg. Directions

Expiration date: _____



Once epinephrine is used, call 911. Student should remain lying down.

Additional information: _____