Pope John Middle School Allergy Action Plan

Student's Name: ____D.O.B: _________________Grade:________
ALLERGY TO: ____
Asthmatic Yes*___ No ___ *Higher risk for severe reaction

Step 1: TREATMENT

Symptoms: Give checked medication: (Determined by Healthcare Provider authorizing treatment)

- If an allergen has not yet caused symptoms: ____Epinephrine ____Antihistamine
- **Mouth** – Itching, tingling, or swelling of lips, tongue, mouth ____Epinephrine ____Antihistamine
- **Skin** – Hives, itchy rash, swelling of the face or extremities ____Epinephrine ____Antihistamine
- **Gut** – Nausea, abdominal cramps, vomiting, diarrhea ____Epinephrine ____Antihistamine
- **Throat** † – Tightening of throat, hoarseness, hacking cough ____Epinephrine ____Antihistamine
- **Lung** † – Shortness of breath, repetitive coughing, wheezing ____Epinephrine ____Antihistamine
- **Heart** † – Weak or thready pulse, low blood pressure, fainting, pale, blueness ____Epinephrine ____Antihistamine
- **Other**† – ____ ____Epinephrine ____Antihistamine
- If reaction is progressing (several of the above areas affected), give: ____Epinephrine ____Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

Epinephrine Auto-Injector (circle one): EpiPen 0.3mg EpiPen Jr. 0.15mg Auvi-Q 0.3mg Auvi-Q 0.15mg

Student can self-administer Epinephrine Auto-Injector (check one): ___Yes ___No

Antihistamine: Give ____
(medication/dose/route)

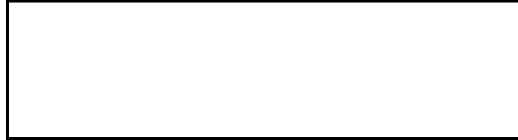
Other: Give____
(medication/dose/route)

Step 2: EMERGENCY CALLS

1. Call 911 PARAMEDICS…………State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Parents: ____ Phone Number: ______________________________
3. Emergency Contact: ________________________________ Phone Number: ______________________________
4. Healthcare Provider: ________________________________ Phone Number: ______________________________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY.

Parent/Guardian Signature: ____ Date: ______________________
Healthcare Provider's Signature: ____ Date: ______________________
Please use box for Healthcare Provider's Address Stamp



PARENT AUTHORIZATION:

I request that my child be given the medication described in the manner above at school by the school nurse. Only if authorized by the Healthcare Provider, I request my child be permitted to carry an epinephrine auto-injector and self-medicate when necessary. If carried on his/her person, I will be cognizant of the expiration date and renew the injector when needed. I relieve Pope John Middle School of any liability which may result from the administration of the above medication to my child or from self-administration when certified by the Healthcare Provider.

Parent/Guardian Signature____Date________________________