Farmington Municipal Schools Health Services
Allergy Action Plan

Parent/Guardian: Please complete information in this top section and sign authorization at the bottom of the page.

Student Name	**DOB**	**Age**	**Grade**	**Medication Allergies**

Prescriber Name	**Prescriber Phone**
Parent/Guardian Name	**Parent/Guardian Phone**
Emergency Contact	**Emergency Contact Phone**

Prescriber: Please complete Allergy Information, Treatment Plan, and Authorization below.

Known Life-Threatening Allergies:

Known Non-Life-Threatening Allergies:

History of Asthma: ☐ Yes ☐ No

Asthma may indicate an increased risk of severe reaction.

History of SEVERE Anaphylactic Reaction: ☐ Yes ☐ No

If **YES**, give epinephrine immediately! Give epinephrine if allergen was **likely** eaten, at onset of any symptoms or if allergen was **definitely** eaten even if **no** symptoms are noticed.

TREATMENT PLAN

For ANY of the following SEVERE SYMPTOMS:

LUNG:	Difficulty breathing/swallowing, wheezing, coughing
HEART:	Dizzy, faint, confused, pale, blue, weak pulse
THROAT:	Tight, hoarse, trouble breathing/swallowing, drooling
MOUTH:	Significant swelling of tongue/lips
SKIN:	Many hives over body, widespread redness over body
GUT:	Nausea, repeated vomiting, severe diarrhea, cramping
OTHER:	Feeling of "doom", anxiety, confusion

Follow this protocol:

1. **INJECT EPINEPHRINE IMMEDIATELY!** Note time.
2. **Call 911.** Request ambulance with epinephrine.
3. Don't hang up & don't leave student.
4. Give additional medications as ordered.
   a. Antihistamine (if ordered below)
   b. Inhaler (Albuterol) if student has asthma
5. Lay student flat and raise legs. If breathing is difficulty or vomiting, sit up or lie on their side.
6. Notify School Nurse, Parent/Guardian & Prescriber.
7. Student must be transported to ER.

For ANY of the following MILD SYMPTOMS:

MOUTH:	Itchy mouth, lips, tongue and/or throat
SKIN:	Itchy mouth
GUT:	Mild nausea/discomfort
NOSE:	Itchy/runny nose

Follow this protocol:

1. **GIVE ANTIHISTAMINE** as ordered.
2. Monitor student, notify School Nurse and Parent/Guardian.
3. Watch student closely for changes.
4. **If symptoms worsen, GO TO EPINEPHRINE PROTOCOL.**

MEDICATION ORDER

Epinephrine
Student's weight
_____ lbs.

☐ **Epinephrine (0.15 mg)** inject intramuscularly ☐ **Epinephrine (0.30 mg)** inject intramuscularly

A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.
Side effects of epinephrine may include: anxiety, tremors, palpitations, dizziness, weakness, tingling & paleness.

Antihistamine
Do not depend on antihistamine or inhaler. **When in doubt, give epinephrine & call 911.**

☐ **Cetirizine/Zyrtec**	☐ **Diphenhydramine/Benadryl**	☐ **Other:**
Dose:	Dose:	Dose:
Route:	Route:	Route:
Frequency:	Frequency:	Frequency:

NOTE: If nurse is not available, the above treatment plan may be provided by trained school personnel for any symptoms listed above.

AUTHORIZATION

Parent/Guardian Consent: I have received, reviewed and understand the above information. I approve of this plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact the prescriber, if necessary. I assume full responsibility for providing the school with the prescribed medications and any other items necessary for my student's care. I give my permission for the school to share the above information with school staff that need to know about my child's condition.

Parent/Guardian Signature: _____ **Date:** _____

I confirm student is capable to safely carry and properly administer above medication(s) ☐ Yes ☐ No

I want to be notified any time a medication on this form is administered to my student ☐ Yes ☐ No

Prescriber Signature: _____

Date: _____

☐ Administration of medication/inhaler by trained staff
☐ Student may self-administer under direct supervision
☐ Student may self-carry medication/inhaler

School Nurse Signature: _____ **Date:** _____

Revised: 03/2024