

# ALLERGY/ANAPHYLAXIS ACTION PLAN

Student  
Photo

Student Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Teacher \_\_\_\_\_  
 School Nurse \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Health Care Provider \_\_\_\_\_ Preferred Hospital \_\_\_\_\_

History of Asthma    No    Yes-Higher risk for severe reaction

**ALLERGY:** (check appropriate) **To be completed by Health Care Provider**

- Foods (list):**
- Medications (list):**
- Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)**
- Stinging Insects (list):**

**RECOGNITION AND TREATMENT**

Chart to be completed by Health Care Provider ONLY		Give CHECKED Medication	
If food ingested or contact w/ allergen occurs:		EpiPen	Antihistamine
No symptoms noted	Observe for other symptoms		
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut+	Nausea, abdominal cramps, vomiting, diarrhea		
Throat+	Tightening of throat, hoarseness, hacking cough		
Lung+	Shortness of breath, repetitive coughing, wheezing		
Heart+	Thready pulse, low BP, fainting, pale, blueness		
Neuro+	Disorientation, dizziness, loss of conscience		
If reaction is progressing (several of the above areas affected), GIVE:			
<b><i>The severity of symptoms can quickly change. +Potentially life-threatening.</i></b>			

**DOSAGE:**

**Epinephrine:** Inject into outer thigh  **EpiPen 0.3 mg** OR  **EpiPen Jr. 0.15 mg** (see reverse for instructions)  
**Antihistamine: Benadryl** \_\_\_\_\_ mg To be given by mouth *only if able to swallow.*  
**Other:** \_\_\_\_\_

- This child has received instruction in the proper use of the EpiPen. It is my professional opinion that this student **SHOULD** be allowed to carry and use the EpiPen independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the EpiPen is self-administered.
- It is my professional opinion that this student **SHOULD NOT** carry the EpiPen.

**Health Care Provider Signature** \_\_\_\_\_ Phone: \_\_\_\_\_ Date \_\_\_\_\_

**EMERGENCY CALLS**

1. **Call 911.** State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call parents/guardian to notify of reaction, treatment and student's health status.
3. Treat for shock. Prepare to do CPR.
4. Accompany student to ER if no parent/guardians are available.

**PREVENTION:**

Avoidance of allergen is crucial to prevent anaphylaxis. Critical components to prevent life threatening reactions:  Indicates activity completed by school staff

	Encourage the use of Medic-alert bracelets
	Notify nurse, teacher(s), front office and kitchen staff of known allergies
	Use non-latex gloves and eliminate powdered latex gloves in schools
	Ask parents to provide non-latex personal supplies for latex allergic students
	Post "Latex reduced environment" sign at entrance of building
	Encourage a no-peanut zone in the school cafeteria
	Other: _____

## Side 2: To Be Completed by Parent/Guardian, Student and School

**Allergy/Anaphylaxis Action Plan** *(continued)* Student Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

### Parent/Guardian AUTHORIZATIONS

- I want this allergy plan implemented for my child; **I want my child to carry the EpiPen** and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of EpiPen.
- I want this plan implemented for my child and I **do not** want my child to self-administer EpiPen.
- It is recommended that backup medication be stored with the school/ school nurse in case a student forgets or loses EpiPen and/or antihistamine. The school district is not responsible or liable if backup medication is not provided to the school/ school nurse and student is without working medication when medication is needed.

**Your signature gives permission for the nurse to contact and receive additional information from your health care provider regarding the allergic condition(s) and the prescribed medication.**

**Parent/Guardian Signature:** \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

### Student Agreement:

- I have been trained in the use of my EpiPen and allergy medication and understand the signs and symptoms for which they are given;
- I agree to carry my EpiPen with me at all times;
- I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) **IMMEDIATELY** when auto-injector EpiPen (epinephrine) is used;
- I will not share my medication with other students or leave my EpiPen unattended;
- I will not use my allergy medications for any other use than what it is prescribed for.

**Student Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

Back-up medication is stored at school Yes No

**Approved by Nurse/Principal Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

### DIRECTIONS FOR EPIPEN® USE

1. Pull off gray activation cap.
2. Hold black tip to outer thigh (apply to thigh **only**).
3. Press hard into outer thigh until auto-injector mechanism functions. Hold in place for 10 seconds.
4. Massage the injection site for 10 seconds.
5. Once EpiPen® is used, call 911/EMS. Take the used EpiPen to the emergency room with you.

### STAFF MEMBERS TRAINED

Name	Title	Location/Room #	Trained By

### EMERGENCY CONTACTS

	Name	Home #	Work #	Cell #
Parent/Guardian				
Parent/Guardian				
Other:				
Other:				