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:		Epinephrine	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 consciousness		
If reaction is progressing (several of the above areas affected), GIVE:			
The severity of symptoms can quickly change. +Potentially life-threatening.			

DOSAGE:

Epinephrine: Inject into outer thigh ☐ **0.3 mg** OR ☐ **0.15 mg**
Antihistamine: Diphenhydramine (Benadryl®) _____ml. To be given by mouth o*nly if able to swallow.*
Other: _____

☐ This child has received instruction in the proper use of the Auto-injector: EpiPen® or Twinject® (circle one). It is my professional opinion that this student **SHOULD** be allowed to carry and use the auto-injector independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the auto-injector is self-administered.
☐ It is my professional opinion that this student **SHOULD NOT** carry an auto-injector.

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.

This form is adapted from The Food Allergy Anaphylaxis Network, "Food Allergy Action Plan" & the Asthma and Allergy Foundation of America, AK Chapter

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 an auto-injector** 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 an auto-injector.
- ☐ I want this plan implemented for my child and I **do not** want my child to self-administer epinephrine.
- ☐ It is recommended that back up medication be stored with the school/school nurse in case a student forgets or loses auto-injector 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.

Parent/Guardian Signature: _____Phone:_____ Date:_____

Student Agreement:

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

Student Signature: _____ Date _____

Approved by Nurse/Principal Signature: _____ Date _____

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.

DELEGATION:

I, parent of the above named student, delegate to the staff members named below the task of administering an auto-injector to my child should he/she show signs and symptoms that might be related to an allergic reaction. I understand that non-licensed staff members will be trained by the school nurse to recognize signs of anaphylaxis and to administer an auto-injector should it be needed. I also understand that personnel will call 911 if an auto-injector is needed. I am delegating this effective today and lasting for the time my child attends this school.

Parent/Guardian Signature: _____Phone:_____ Date:_____

STAFF MEMBERS TRAINED

Name	Title	Location/Room #	Trained By

EMERGENCY CONTACTS

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

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