Allergy & Anaphylaxis Action Plan

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

Place child's photo here

To be completed by healthcare provider

ALLERGY TO: _____
History: _____

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

◊ STEP 1: TREATMENT

SYMPTOMS: GIVE CHECKED MEDICATION(S)		
➢Suspected ingestion or sting, but *no symptoms*	☐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 <u>first</u>, then can give antihistamine!
<u>Remember</u> - severity of symptoms can quickly change!

<u>DOSAGE</u>

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: _____

Student Name: _____ **DOB:** _____

TRAINED STAFF MEMBERS

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

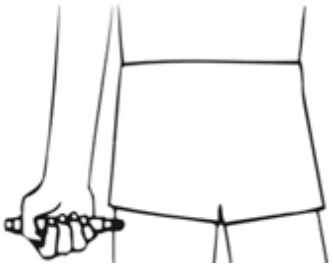
Self-carry contract on file. ☐Yes ☐No Medication located in: _____

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

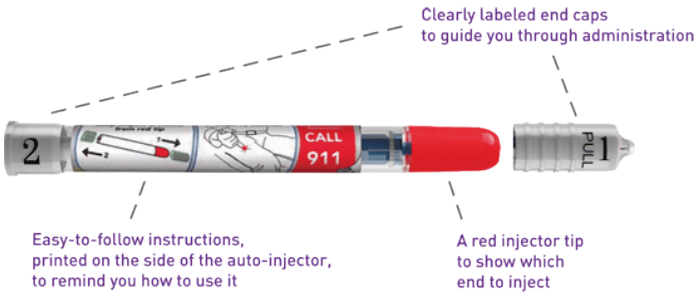
Expiration date: _____

- 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:_____

_____

_____

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