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: Liquid 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.
4. Accompany student to ER if no parent/guardians are available.

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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.** _____

Each school will have 2 auto-injectors and liquid Diphenhydramine (Benadryl®) available during regular school hours. If your child participates in before or after school activities, your child will need to have an auto-injector on their person.

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.

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 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** _____

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:

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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