# 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 ☐NO *Higher risk for severe reaction

## ◊ 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 first, then can give antihistamine!
Remember - severity of symptoms can quickly change!

**DOSAGE**

**Epinephrine**: inject intramuscularly (check one):
☐ EpiPen®0.3 mg ☐ EpiPen®Jr.0.15 mg
☐ Administer 2nd dose if symptoms do not improve in 15 – 20 minutes

**Antihistamine**: give_____
(medication/dose/route

****IF ANTIHISTAMINE HAS BEEN GIVEN, PARENT MUST BE NOTIFIED AND STUDENT PICKED UP FROM SCHOOL****

**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: _____ Start Date: _____End 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. **This Health Care Plan will be effective for one school year.**

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

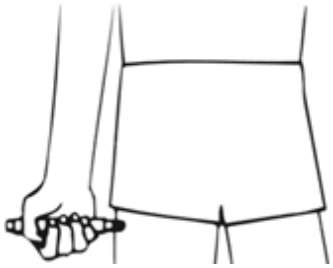
**Student Name: _____ DOB: _____**

**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.

**Once EpiPen is used, call 911. Student should remain lying down.**

**TRAINED STAFF MEMBERS**

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

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

Additional information:_____

_____

_____