



Health Care Action Plan – Allergies

Please return form to: School: _____ Fax: _____

Name: _____ DOB: _____

SEVERE ALLERGY TO: _____

Symptoms and History of Reactions

Other allergies (food, insects, medication, etc.)

Medications provided to school for treatment of allergy

School accommodations and treatments (to be filled out by school nurse)

Emergency Information

List contacts in order of preference. Also, write preference of contact method, 1 being the highest, 3 the lowest.

Contact #1 name: _____ Contact #2 name: _____
Home phone: _____ Preference: _____ Home phone: _____ Preference: _____
Cell phone: _____ Preference: _____ Cell phone: _____ Preference: _____
Work phone: _____ Preference: _____ Work phone: _____ Preference: _____

Health Care Provider who should be contacted regarding the allergic reaction:

Name: _____ Phone: _____

Parent/Guardian Signature

Date

School Nurse Signature

Date

Allergy & Anaphylaxis Action Plan

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



ALLERGY TO: _____

History: _____

Asthma: YES NO *Higher risk for severe reaction

◇ STEP 1: TREATMENT ◇

SYMPTOMS: GIVE CHECKED MEDICATION(S)		
➤ Suspected ingestion or sting, but <i>no symptoms</i>	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
MILD SYMPTOMS: Itchy mouth, few hives, mild itch, mild nausea/discomfort		<input type="checkbox"/> Antihistamine
MOUTH Itching, tingling, or mild swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
SKIN: Flushing, hives, itchy rash	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
STOMACH Nausea, abdominal pain or cramping, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
‡ THROAT Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
‡ LUNG Shortness of breath, repetitive coughing, wheezing <input type="checkbox"/> Inhaler	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
‡ HEART Weak or thready pulse, dizziness, fainting, pale, or blue hue to skin	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
➤ If reaction is progressing (several of the above areas affected), give	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> 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 Twinject®0.3 mg Twinject®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 Asthma Care Plan/Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

To be completed by healthcare provider

Student Name: _____ DOB: _____

TRAINED STAFF MEMBERS

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

- Room _____
 Room _____
 Room _____
 Room _____
 Room _____

Self-carry contract on file. Yes No

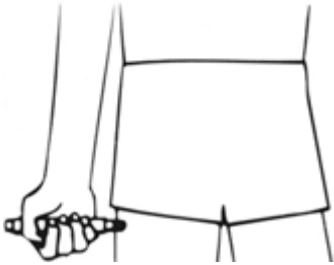
Medication located in: _____

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."

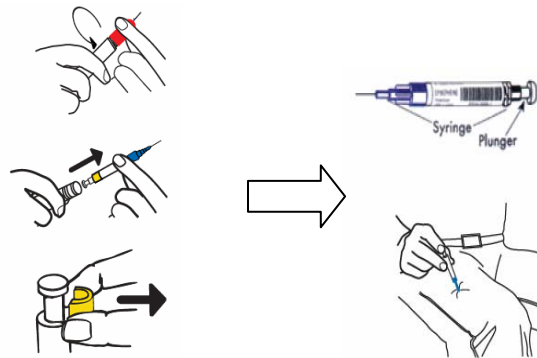


- ⌚ Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.



SECOND DOSE ADMINISTRATION:

If a second dose is required, see specific administration instructions, and follow school district policy.



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

Additional information: _____