NON-FOOD ALLERGY/ANAPHYLAXIS ACTION PLAN

Student Name____________________________________Birthdate___________Grade_______

SIDE 1: TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

Allergy to: (Complete appropriate allergen information)

Medications (list):____

Latex: ❑ Anaphylaxis or ❑ Contact Dermatitis

Stinging Insects (list):____

History of Asthma: ❑ Yes (Higher risk for severe reaction) ❑ No

Severe Symptoms
One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling tongue and/or lips
SKIN: Many hives over body

Or combination of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, crampy pain

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911 then notify Parent/Guardian
3. Begin monitoring (see box below)
4. Give additional medications as ordered
   - Antihistamines
   - Inhaler (bronchodilator)

Mild Symptoms Only
MOUTH: Itchy mouth
SKIN: A few hives, mild itch
GUT: Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student, notify parent
3. If symptoms progress USE EPINEPHRINE (see above)
4. Begin monitoring (see box below)

Medications Order

Epinephrine (Brand and Dose) ____

Antihistamine (Brand and Dose) ____

Other (e.g., inhaler-bronchodilator if asthmatic) ___________________________________

❑ This child has received instruction in the proper use of the Auto-injector and SHOULD be allowed to carry the Auto-injector independently. He/she has been advised to inform a responsible adult if the Auto-injector is used.

❑This child SHOULD NOT carry the Auto-injector.

Monitoring
Stay with student. Call the ambulance and let them know epinephrine was given. Call Parent/Guardian. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. Treat for shock. Treat student even if parent cannot be reached.

Healthcare Provider Signature____Date_________

Print Name ____Phone______________

SIDE 2: TO BE COMPLETED BY PARENT/GUARDIAN

Contacts

Mom/Guardian: Call 1st ______________________________Call 2nd _________________________

Dad/Guardian: Call 1st _______________________________ Call 2nd ________________________

Other Emergency Contacts

Name/Relationship: ____Phone ____________________

Name/Relationship: ____Phone ____________________

Parent Authorization

❑ I want this allergy plan implemented for my child; **I want my child to carry the 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 the Auto-injector.

❑ I want this allergy plan implemented for my child; **I do not want my child to carry the Auto-injector.**

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: ____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 **IMMEDIATELY** when the Auto-injector is used.

❑ I will not share my medication with other students.

❑ I will not use my allergy medication for any other use than what is prescribed for.

Student Signature: ____Date_________

Reviewed by School Nurse: ____ Date________