Allergy & Anaphylaxis Action Plan

Place child's photo here

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

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,mg /route

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

Asthma Rescue (if asthmatic): give _____
(medication/dose,puffs/route)

Provider (print) _____ Phone Number: _____ Fax _____

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: _____

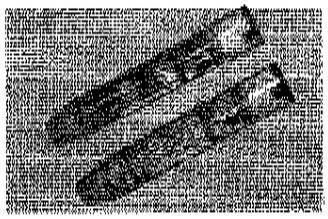
School Nurse: _____ Date: _____

Student Name: _____ **DOB:** _____

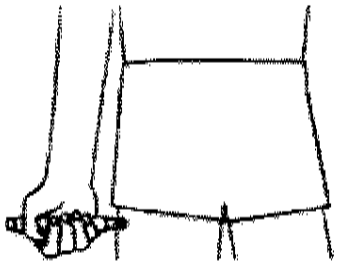
Medication located in: _____

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.

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

Medication located in: _____

Medication expires:

Antihistamine: _____

Epipen : _____