

### 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"/>	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Inhaler		
‡ 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
- Administer 2<sup>nd</sup> 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 \_\_\_\_\_

Provider (print) \_\_\_\_\_ (medication/dose,puffs/route)  
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: \_\_\_\_\_

To be completed by healthcare provider

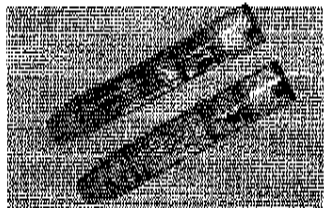
Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Medication located in: \_\_\_\_\_

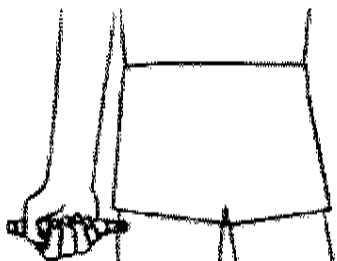
**EpiPen® and EpiPen® Jr. Directions**

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 : \_\_\_\_\_