Allergy Action Plan

Students Name:_____ **D.O.B:**_____

ALLERGY TO:_____

Asthmatic ☐Yes* ☐No *Higher risk for severe reaction

SYMPTOMS:	Give checked medication as determined by Physician:
If an exposure to the allergen has occurred, but there are NO symptoms:	☐Antihistamine ☐Epinephrine
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	☐Antihistamine ☐Epinephrine
Skin: Hives, itchy rash, swelling of the face or extremities	☐Antihistamine ☐Epinephrine
♦Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐Antihistamine ☐Epinephrine
♦Throat: Tightening of throat, hoarseness, hacking cough	☐Antihistamine ☐Epinephrine
♦Lung: Shortness of breath, repetitive coughing, wheezing	☐Antihistamine ☐Epinephrine
♦Heart: Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐Antihistamine ☐Epinephrine
Other symptoms:	☐Antihistamine ☐Epinephrine
If reaction is progressing, several of the above areas affected:	☐Antihistamine ☐Epinephrine

♦Potentially life threatening. The severity of symptoms can quickly change.

DOSAGE:

Epinephrine: inject intramuscularly (see reverse side for instructions)

☐EpiPen® ☐EpiPen® Jr. ☐Twinject® 0.3 mg ☐Twinject® 0.15 mg

Antihistamine: _____
Medication/Dose/Route

Other:_____
Medication/Dose/Route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Doctor:_____ Phone Number:_____
3. Parent:_____ Phone Number:_____
4. Other Emergency Contacts:

   Name:_____ Phone Number:_____

   Name:_____ Phone Number:_____

I acknowledge that it may be necessary for the administration of Epinephrine to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and I agree to indemnify and hold harmless the School District and its employees and agents against any claims. I agree to the terms of the procedures for the administration of medication. I further completely release Egg Harbor City Public School District and its employees and agents of any liability or obligation of any nature in any way related to the administration of medication.

Parent/Guardian signature _____ Date_____

Student Name: _____

Monitoring

Stay with student; alert healthcare professionals and parent.

Tell rescue squad epinephrine was given. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.

To Be Completed By Parent/Guardian

I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and I agree to indemnify and hold harmless the School District and its employees and agents against any claims. I agree to the terms of the procedures for the administration of medication. I further completely release Egg Harbor City Public School District and its employees and agents of any liability or obligation of any nature in any way related to the administration of medication. I also understand that my signature on this form denotes permission for the school nurse and the prescribing physician to confer regarding the administration/monitoring of this medication.

Parent/Guardian signature _____ Date _____