

Allergy & Anaphylaxis Action Plan

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

Place child's
photo here

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
 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 _____

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: _____

Student Name: _____ **DOB:** _____

To be completed by healthcare provider

Medication located in: _____

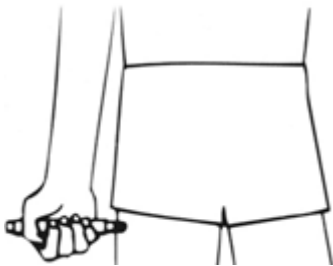
EpiPen® and EpiPen® Jr. Directions

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 : _____