ALLERGY EMERGENCY ACTION PLAN

(to be completed by physician at the beginning of each school year and kept on file with the school nurse)

Student's Name:_____ DOB:_____ School Year:_____

ALLERGY TO:_____

Asthmatic *_____Yes _____No (*Higher risk for severe reaction) Today's Date: _____

STEP 1: TREATMENT (to be determined by physician)

Symptoms:		**Give Checked Medication:**
1. If a food allergen has been ingested, *but no symptoms*:		____Epinephrine ____Antihistamine
If a bite/sting has occurred, *but no symptoms*:		____Epinephrine ____Antihistamine
2. Mouth	Itching, tingling, or swelling of lips, tongue, mouth	____Epinephrine ____Antihistamine
3. Skin	Hives, itchy rash, swelling of the face or extremities	____ Epinephrine ____Antihistamine
4. Gut	Nausea, abdominal cramps, vomiting, diarrhea	____ Epinephrine ____Antihistamine
5. Throat	Tightening of throat, hoarseness, hacking cough	____Epinephrine ____Antihistamine
6. Lung	Shortness of breath, repetitive coughing, wheezing	____Epinephrine ____Antihistamine
7. Heart	Weak or thready pulse, low blood pressure, fainting, pale, blueness	____Epinephrine ____Antihistamine
8. Other:		____Epinephrine ____Antihistamine
If reaction is progressing (several of the above areas affected), give:		____Epinephrine ____Antihistamine

MEDICATION AND DOSAGE FOR ALLERGIC REACTION:

Epinephrine: Inject intramuscularly (circle one) EpiPen®0.3 mg EpiPen® Jr. 0.15 mg (per prescription label instructions)

Antihistamine: give _____(medication/dose/time/route)

Other: give _____(medication/dose/time/route)

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

STEP 2: EMERGENCY CALLS

1. Must Call 911 or EMS if EpiPen has been administered
   State that an allergic reaction has been treated and additional epinephrine may be needed. Note time medications were given.
   EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911
2. Parent_____ Phone Number(s)_____
3. Emergency Contact_____Phone Number(s)_____

PHYSICIAN AUTHORIZATION FOR MEDICATION

Doctor's Name_____Address_____ Phone Number_____

☐ I have instructed _____ (student) in the proper way to use his/her EpiPen. It is my professional opinion that he/she **SHOULD BE ALLOWED** to carry and self-administer the prescribed medication while at school or school related events.

☐ It is my professional opinion that _____ (student) **SHOULD NOT** be allowed to carry and self-administer his/her EpiPen while on school property or school related events.

Physician's Signature:_____ Date:_____

I agree to the information and conditions in this Action Plan and understand that a copy of this Action Plan may be given to teachers, school bus drivers, or other school personnel as necessary for the health and safety of my child.

Parent/Guardian's Signature:_____ Date:_____