

Allergy and Anaphylaxis Action Plan and Medication Orders

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

School: _____ Teacher: _____

Place child's photo here

ALLERGY TO: _____

History: _____

Asthma: YES (Higher risk for severe reaction) NO

◇ STEP 1: TREATMENT ◇

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, crampy pain



1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*

 - Antihistamine
 - Inhaler (quick relief) if asthma

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort



1. GIVE ANTIHISTAMINE

2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

DOSAGE

Epinephrine: inject intramuscularly using autoinjector (check one): **0.3 mg** **0.15 mg**

Administer 2nd dose if symptoms do not improve in _____ minutes

Antihistamine: (brand and dose) _____

If Asthmatic: (brand and dose) _____

Student's condition warrants accommodations from food service (please complete the bottom of the back page)

Student has been instructed and is capable of carrying and self administering own medication. Yes No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ 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.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

To be completed by healthcare provider

Student Name: _____ DOB: _____

TRAINED/DELEGATED STAFF MEMBERS

- | | |
|----------|------------|
| 1. _____ | Room _____ |
| 2. _____ | Room _____ |
| 3. _____ | Room _____ |
| 4. _____ | Room _____ |
| 5. _____ | Room _____ |

Self-carry contract on file. Yes No

Medication located in: _____

EpiPen® and EpiPen® Jr.

Expiration date: _____

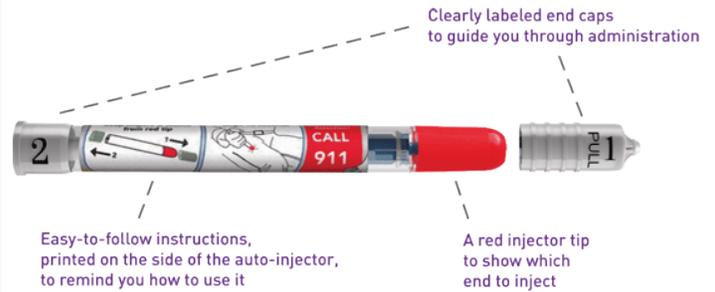
- Pull off blue activation cap.



- Hold orange tip near outer thigh (through clothing, if needed)
- 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.

Adrenacllick 0.3 mg. and 0.15 mg

Expiration date: _____



Auvi-Q 0.3 mg. and 0.15 mg

Expiration date: _____

- Pull the Auvi-Q™ from the outer case.
- Pull off Red safety guard.
- Place black end against the middle of the outer thigh (through clothing, if needed), then press firmly, and hold in place for 5 seconds.



**Once epinephrine is used, call 911.
Student should remain lying down or in a comfortable position.**

Additional information: _____

MEDICAL STATEMENT FOR SCHOOL MEAL MODIFICATION

I certify that the student's food allergy rises to the level of a disability & qualifies for school meal modification.

1. List foods to be omitted: _____

2. Indicate food modification/substitutions: _____

Signature by a licensed MD or DO only _____ Date _____