# ALLERGY ACTION PLAN

**USE 1 FORM PER CHILD FOR EACH ALLERGEN**

Student _____School_____.

DOB _____ Teacher/Grade _____

Allergy to _____

Asthmatic? ❑ Yes* ❑ No *Higher risk for severe reaction

## STEP 1 - TREATMENT

**SEND STUDENT TO HEALTH OFFICE ACCOMPANIED BY RESPONSIBLE PERSON.**

*The severity of symptoms can quickly change. †Potentially life threatening.*

| **Symptoms** | | **Give checked Medication**** ***To be determined by physician authorizing treatment* | |
|---|---|---|---|
| ♦ | If a student has been exposed to/ingested an allergen but has NO symptoms: | ❑ Epinephrine | ❑ Antihistamine |
| ♦ Mouth | Itching, tingling, or swelling of lips, tongue, mouth: | ❑ Epinephrine | ❑ Antihistamine |
| ♦ Skin | Hives, itchy rash, swelling of the face or extremities: | ❑ Epinephrine | ❑ Antihistamine |
| ♦ Gut | Nausea, abdominal cramps, vomiting, diarrhea: | ❑ Epinephrine | ❑ Antihistamine |
| ♦ Throat† | Tightening of throat, hoarseness, hacking cough: | ❑ Epinephrine | ❑ Antihistamine |
| ♦ Lung† | Shortness of breath, repetitive coughing, wheezing: | ❑ Epinephrine | ❑ Antihistamine |
| ♦ Heart† | Thready pulse, low blood pressure, fainting, pale, blueness: | ❑ Epinephrine | ❑ Antihistamine |
| ♦ Other† | _____ : | ❑ Epinephrine | ❑ Antihistamine |
| ♦ | If reaction is progressing, (several of the above areas affected), give: | ❑ Epinephrine | ❑ Antihistamine |

**MEDICATION:** **START DATE** _____ **END DATE** _____

**Epinephrine**: Inject intramuscularly.

**Important**; *Asthma inhalers and/or antihistamines cannot be depended upon to replace epinephrine in anaphylaxis.*

❑ Epinephrine Autoinjector **0.3mg**

❑ Epinephrine Autoinjector **0.15mg**

**Antihistamine:** Give _____

*antihistamine/dose/route*

**Other**: Give _____

*medication/dose/route*

**Parent/Guardian Signature**_____**Date** _____

**Prescriber Name**_____**Phone**_____

**Prescriber Signature**_____**Date** _____

## STEP 2 - EMERGENCY CALLS

**PARAMEDICS (911) MUST BE CALLED IF EPIPEN OR AUVI-Q IS GIVEN. EPIPEN OR AUVI-Q ONLY LAST 15-20 MINUTES.**

**Call 911. State that an anaphylactic reaction has been treated, type of treatment given (i.e., EpiPen or Auvi-Q) and that additional epinephrine may be needed. Always send empty autoinjector to ER with student. Contact Parent/Guardian.**

**EVEN IF PARENT/GUARDIAN IS UNAVAILABLE, DO NOT HESITATE TO MEDICATE CHILD & CALL 911**

**EMERGENCY CONTACTS**

| | Name | Relationship | Telephone number |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |

****** Form on Page 2 to be completed ONLY if student will be carrying an Epinephrine Autoinjector ******

******(To be completed ONLY if student will be carrying an Epinephrine Autoinjector)******

## AUTHORIZATION FOR STUDENT POSSESSION AND USE OF AN EPINEPHRINE AUTOINJECTOR

## (In accordance with ORC 3313.718/8313.141)

| Student name |
|---|
| Student address |

**This section must be completed and signed by the student's parent or guardian.**

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

| **Parent/Guardian signature** | Date |
|---|---|
| Parent/Guardian name | Parent/Guardian emergency telephone number ( ) |

**This section must be completed and signed by the medication prescriber.**

| Name and dosage of medication | |
|---|---|
| Date medication administration begins | Date medication administration ends (if known) |

| Circumstances for use of the epinephrine autoinjector |
|---|
| Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief |

Possible severe adverse reactions:

| To the student for which it is prescribed (that should be reported to the prescriber) |
|---|
| To a student for which it is **not** prescribed who receives a dose |

| Special instructions |
|---|

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

| **Prescriber signature** | Date |
|---|---|
| Prescriber name | Prescriber emergency telephone number ( ) |

Developed in collaboration with the Ohio Association of School Nurses.

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