Allergy Action Plan

Name:__________________________ D.O.B.__________ Weight_______

Place student photo here

Allergy to: ____

History of Anaphylaxis? ☐YES ☐No type of reaction_____________

Asthma: ☐Yes (higher risk for a severe reaction) ☐No

Extremely reactive to the following:______________________________

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted

Any SEVERE SYMPTOMS after suspected or known ingestion/exposure:

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 care plan)
4. Give additional medications:*
   - -Antihistamine
   - -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE. Delegate may not administer inhaler or antihistamine

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

→

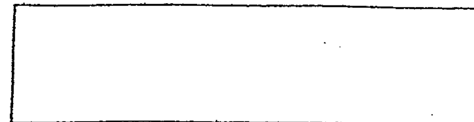
1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Monitor student (see care plan)

Medications/Doses

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg
May Repeat x________ every________minutes. (In the absence of a school nurse a trained delegate may give epinephrine only for a multisystem reaction. Delegates may not administer antihistamine or asthma medications.)
Antihistamine: Give Diphenhydramine PO ___ 12.5 mg ___25 mg ___50mg _________ Other
Other (inhaler/bronchodilator if asthmatic):______________________________

☐ Student may self-administer epinephrine ☐ Student may self-administer antihistamine

Doctor's Signature________________________ Date_______ Office Stamp



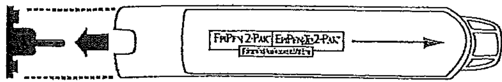
The school nurse has permission to administer the above medications to my child as prescribed by physician. I/we give permission to the school nurse to contact the physician if necessary. I/we acknowledge that the district or its employees shall incur no liability as a result of the administration of the above medication or injury arising from the self adminstration of medication by the pupil and idemnify and hold harmless the disrict and its employees or agents against claims arising out of the self-administration of medication by my child.

Parent/Guardian Signature____________________________________ Date____________

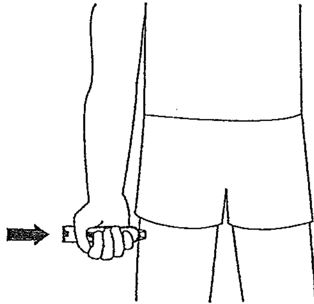
TURN FORM OVER Form adapted from Food Allergy & Anaphylaxis Network 9/2011

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



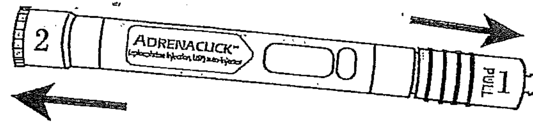
- Hold orange tip near outer thigh (always apply to thigh)

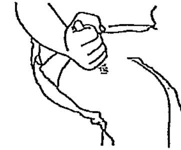


- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.
  Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds

DEY® and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions





Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (__) _____-_______) Doctor: ________________ Phone: (__) _____-_______

Parent/Guardian: ________________________________ Phone: (__) _____-_______

Other Emergency Contacts

Name/Relationship: ________________________________ Phone: (__) _____-_______

Name/Relationship: ________________________________ Phone: (__) _____-_______

Hillside Public Schools
Hillside, N.J.

REQUEST FOR MEDICATIONS TO BE ADMINISTERED IN SCHOOL

Name of Pupil: ______________________ Grade: __________ DOB____________

Address: __________________________________

Parent(s)/Guardian: __________________________

Emergency Telephone Number (s) ________________________________

Medication: ____

Dosage ____

Time/Circumstances of Administration: ____________________________________

Duration: ____

Restrictions: Physical Education ______Yes ______ No Restrictions

If yes, how long____________________________________

Other____

Physician's Name (Please Print) ____

Address: ____

Telephone Number: ____

Physician's Signature: ____________________________________ Date: _______

PUPIL SELF ADMINISTRATION OF MEDICATION (PHYSICAN'S CERTIFICATION)

I certify that the above named pupil is capable of and has been instructed in the proper use/ method of administration and must be in possession of medication (as described above) at all times.

PHYSICIAN'S SIGNATURE ____________________________ DATE__________

Parent/ Guardian Consent

The school nurse at __________________ School has permission to administer the above medication to my child as prescribed by physician. We/I give permission to the school nurse to contact the physician if necessary. We/I also acknowledge that the district or its employees shall incur no liability as a result of the administration of medication by of the above medication or injury arising from the self administration of medication by the pupil and indemnify and hold harmless the district and its employees or agents against any claims arising out of the self –administration of medication by my child.

Parent/Guardian Signature: ____________________________________ Date: _______