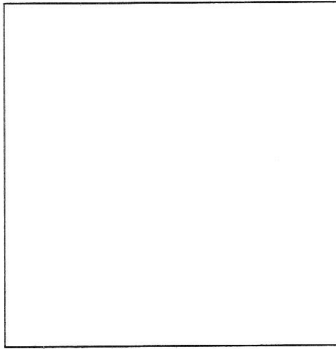


# ALLERGY ACTION PLAN

## 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

- ◆ If a student has been exposed to/ingested an allergen but has NO symptoms:
- ◆ Mouth Itching, tingling, or swelling of lips, tongue, mouth:
- ◆ Skin Hives, itchy rash, swelling of the face or extremities:
- ◆ Gut Nausea, abdominal cramps, vomiting, diarrhea:
- ◆ Throat† Tightening of throat, hoarseness, hacking cough:
- ◆ Lung† Shortness of breath, repetitive coughing, wheezing:
- ◆ Heart† Thready pulse, low blood pressure, fainting, pale, blueness:
- ◆ Other† \_\_\_\_\_ :
- ◆ If reaction is progressing, (several of the above areas affected), give:

#### Give checked Medication\*\*

*\*\*To be determined by physician authorizing treatment*

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
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| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> 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 <b>not</b> prescribed who receives a dose

Special instructions  _____
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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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