ALLERGY/ANAPHYLAXIS ACTION PLAN

Student Photo

Student Name _____ **D.O.B.** _____ **Teacher** _____
School Nurse _____ **Phone Number** _____
Health Care Provider _____ **Preferred Hospital** _____
History of Asthma No Yes-Higher risk for severe reaction

ALLERGY: (check appropriate) **To be completed by Health Care Provider**

- ☐ **Foods (list):**
- ☐ **Medications (list):**
- ☐ **Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)**
- ☐ **Stinging Insects (list):**

RECOGNITION AND TREATMENT

Chart to be completed by Health Care Provider ONLY		**Give CHECKED Medication**	
If food ingested or contact w/ allergen occurs:		EpiPen	Antihistamine
No symptoms noted	Observe for other 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 BP, fainting, pale, blueness		
Neuro+	Disorientation, dizziness, loss of conscience		
If reaction is progressing (several of the above areas affected), GIVE:			
The severity of symptoms can quickly change. +Potentially life-threatening.			

DOSAGE:

Epinephrine: Inject into outer thigh ☐ **EpiPen 0.3 mg** OR ☐ **EpiPen Jr. 0.15 mg** (see reverse for instructions)
Antihistamine: Benadryl _____mg To be given by mouth *only if able to swallow.*
Other: _____

☐ This child has received instruction in the proper use of the EpiPen. It is my professional opinion that this student **SHOULD** be allowed to carry and use the EpiPen independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the EpiPen is self-administered.
☐ It is my professional opinion that this student **SHOULD NOT** carry the EpiPen.

Health Care Provider Signature _____ Phone: _____ Date _____

EMERGENCY CALLS

1. **Call 911.** State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call parents/guardian to notify of reaction, treatment and student's health status.
3. Treat for shock. Prepare to do CPR.
4. Accompany student to ER if no parent/guardians are available.

PREVENTION: Avoidance of allergen is crucial to prevent anaphylaxis. Critical components to prevent life threatening reactions: ☑ Indicates activity completed by school staff

	Encourage the use of Medic-alert bracelets
	Notify nurse, teacher(s), front office and kitchen staff of known allergies
	Use non-latex gloves and eliminate powdered latex gloves in schools
	Ask parents to provide non-latex personal supplies for latex allergic students
	Post "Latex reduced environment" sign at entrance of building
	Encourage a no-peanut zone in the school cafeteria
	Other:

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This form is adapted from The Food Allergy Anaphylaxis Network. "Food Allergy Action Plan" by the Alaska Asthma Coalition.

Side 2: To Be Completed by Parent/Guardian, Student and School

Allergy/Anaphylaxis Action Plan *(continued)* **Student Name** _____ **D.O.B.** _____

Parent/Guardian AUTHORIZATIONS

- ☐ I want this allergy plan implemented for my child; **I want my child to carry the EpiPen** and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of EpiPen.
- ☐ I want this plan implemented for my child and I **do not** want my child to self-administer EpiPen.
- ☐ It is recommended that backup medication be stored with the school/ school nurse in case a student forgets or loses EpiPen and/or antihistamine. The school district is not responsible or liable if backup medication is not provided to the school/ school nurse and student is without working medication when medication is needed.

Your signature gives permission for the nurse to contact and receive additional information from your health care provider regarding the allergic condition(s) and the prescribed medication.

Parent/Guardian Signature: _____Phone:_____ Date:_____

Student Agreement:

- ☐ I have been trained in the use of my EpiPen and allergy medication and understand the signs and symptoms for which they are given;
- ☐ I agree to carry my EpiPen with me at all times;
- ☐ I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) **IMMEDIATELY** when auto-injector EpiPen (epinephrine) is used;
- ☐ I will not share my medication with other students or leave my EpiPen unattended;
- ☐ I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature: _____ **Date** _____

☐ Back-up medication is stored at school ☐ Yes ☐ No

Approved by Nurse/Principal Signature: _____ **Date** _____

DIRECTIONS FOR EPIPEN® USE

1. Pull off gray activation cap.
2. Hold black tip to outer thigh (apply to thigh **only**).
3. Press hard into outer thigh until auto-injector mechanism functions. Hold in place for 10 seconds.
4. Massage the injection site for 10 seconds.
5. Once Epipen® is used, call 911/EMS. Take the used EpiPen to the emergency room with you.

STAFF MEMBERS TRAINED

Name	Title	Location/Room #	Trained By

EMERGENCY CONTACTS

	Name	Home #	Work #	Cell #
Parent/Guardian				
Parent/Guardian				
Other:				
Other:				

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Ohio Department of Health

Authorization for Student Possession and Use of an Epinephrine Autoinjector

In accordance with ORC 3313.718/3313.141

A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.

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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