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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