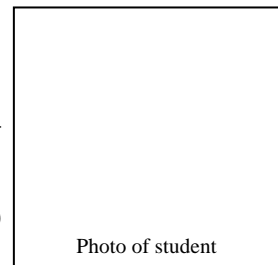


_____ 's **Emergency Allergy Action Plan**

Student's Name _____

Student's DOB: _____ School: _____ Teacher/Homeroom: _____



Allergy to: _____ (Do separate order if both insect and food allergy)

Asthma: Yes* No *Higher risk for severe reaction

Extremely reactive to the following: _____

- If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* (eaten or stung).
- If checked, give epinephrine immediately if the allergen was *definite* (eaten or stung) even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following life threatening symptoms:

- 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 &/or lips)
- SKIN: Many hives over body

Or combination of symptoms from different body areas:

- SKIN: Hives, itchy rashes, swelling (eyes, lips)
- GUT: Vomiting, diarrhea, crampy pain



1. INJECT EPINEPHRINE IMMEDIATELY

2. Call **911** *State that an allergic reaction has been treated, and additional epinephrine may be needed*
 3. Monitor student
 4. Give additional medications:*
-Antihistamine
-Inhaler (bronchodilator) if ordered for asthma
- *Antihistamines & inhaler bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis).

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. **Monitor** student
4. If symptoms become severe use **Epinephrine**

Physician Medication Order:

Epinephrine: inject intramuscularly (choose one):

- EpiPen® (0.3 mg) student 66 lbs or more
- Adrenaclick (0.3 mg) student approximately 66 lbs or more
- EpiPen® Jr. (0.15 mg) student 33 to 66 lbs
- Adrenaclick (0.15 mg) student 33 to 66 lbs

Antihistamine brand: _____ **Dose:** _____ **Route:** _____

Other (e.g., inhaler-bronchodilator): _____ **Dose:** _____ **Route:** _____

School Considerations: May Self Carry (5th grade and higher) Yes No

Epinephrine must accompany the student if he/she is outside. Yes No

Epinephrine must accompany the student if he/she is off school ground (i.e., field trip). Yes No

Epinephrine must be available on routine bus ride transportation. Yes No

Physician Signature*: _____ Date: _____

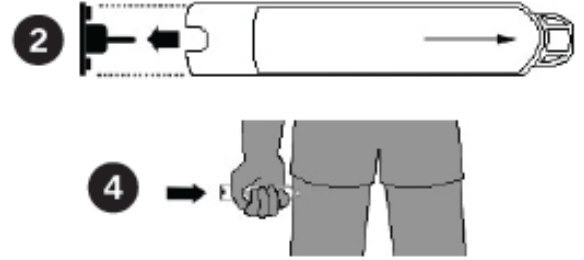
Physician Office: _____ Phone: _____ Fax: _____

*MD- please print and sign. Parent to complete their section on back and return to school nurse with medications ordered ASAP. You may also fax this page without loss of confidentiality to: _____. Thank you!

INJECT EPINEPHRINE IMMEDIATELY

EpiPen® (Epinephrine) Auto-injector directions:

1. Remove the EpiPen Auto-injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds
5. Remove and massage the area for 10 seconds.



Call 911. Request ambulance

- Consider giving additional medications (following or with the epinephrine):
 - (a) Antihistamine if ordered; (b)- Inhaler (bronchodilator) if has asthma medication ordered
- Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side. If allergic reaction is due to bee sting, remove stinger, apply cool compress to site, and elevate.
- **SECOND DOSE ADMINISTRATION** If symptoms do not improve, or symptoms return, a second dose of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts

Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return. Parent may divert ambulance if present and assumes responsibility for student.

Staff Trained:

Name:	

PARENT MUST COMPLETE:

EMERGENCY CONTACTS

1 Parent/Guardian: _____ Phone (w): _____ (c): _____ (h): _____
 2 Parent/Guardian: _____ Phone (w): _____ (c): _____ (h): _____

Children with food allergies **MAY NOT EAT** during routine bus transportation.

I give permission to school staff to give the medication listed above as instructed. School staff may exchange information with MD. Fax transmittal between school and medical office may not be confidential

I will provide an Epinephrine self injector for my child. If my child self carries, I will provide a back up pen for the school office.

I agree that my child (5th grade or higher) may carry his/her epinephrine. Yes No

Parent /Guardian Signature: _____ Date: _____

RN must review plan. Copy of care plan to be kept in main office and in classroom(s)	
School Nurse Signature: _____	Date: _____

