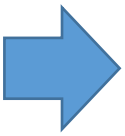
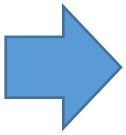
Place Student's Picture Here

Allergy/Anaphylaxis Action Plan

Name of Student: _____Grade:_____ School Year: _____
Program: _____ Date of Birth: _____
Allergy to: _____
Asthma: _____ Yes (higher risk for severe reaction _____ No

Dear Parent/Guardian:
It is indicated on your Emergency Medical Information that he/she has a food or latex allergy. In order to provide the best medical care for your child, we request that you complete this form and return it to the nurse immediately.

Any SEVERE SYMTPOMS are suspected or known ingestion: **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 Combination of symptoms from different body area: SKIN: Hives, itchy rashes, swelling GUT: Vomiting, diarrhea, crampy pain		**1. INJECT EPINEPHRINE IMMEDIATELY** 2. Call 911 3. Begin monitoring (see box below) 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.
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 professional and parent 3. If symptoms progress (see above), USE EPINEPHRINE 4. Begin monitoring (see box below)

Monitoring
Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.

Extremely reactive to the following foods:_____
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.

Medications needed

1. Epinephrine: Inject into outer thigh _____ EpiPen 0.3 mg **(Please attach the Authorization to carry EpiPen y form).**
2. Antihistamine: Benadryl _____ mg to be given by mouth *only* if able to swallow **(Please attach Non-Prescription Authorization form).**

1. **My child has required an EpiPen in the past. (month and year)** _____
2. **Date of last allergic reaction. (month and year)** _____
3. **My child no longer has a food or latex allergy- please remove this from your information.**

Form provided courtesy of the Food Allergy Research & Education (FARE) (www.foodallergy.org) 4/2013

Parent/Guardian AUTHORIZATIONS

_____ I want this allergy plan implemented for my child: I want my child to carry the EpiPen and 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 and/or 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 and/or Nurse and student is without working medication when medication is needed.

I hereby give my permission for the medication(s) listed above to be given to my child by the nurse or the designee of the nurse. I relieve the Delaware Area Career Center School Board and its employees of liability in the administration of this medication.

Your signature gives permission for the nurse to contact and receive additional information from your healthcare 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, administration, 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: _____ Phone: _____ Date: _____

School Health Care Professional Authorization:

____This student 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 student 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.

____ Back-up medication is stored at the school ___Yes ___ No

School Health Care Provider Signature_____Phone:_____Date:_____

Physician Authorization:

Physician's Name (Print) _____

Physician's Signature _____ Date _____

Contacts:

Parent/Guardian: _____ Phone: _____

Other Emergency Contacts:

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____