

Allergy and Anaphylaxis Action Plan and Medication Orders

Student's Name: _____ D.O.B. _____ Grade: _____

School: _____ Teacher: _____

Place child's photo here

ALLERGY TO: _____

History: _____

Asthma: YES (Higher risk for severe reaction) NO

◇ STEP 1: TREATMENT

Any SEVERE SYMPTOMS after 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

Or **combination** of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, crampy pain



1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*

 - Antihistamine
 - Inhaler (quick relief) if asthma

*Antihistamine & quick relief inhalers 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 professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

DOSAGE

Epinephrine: inject intramuscularly using autoinjector (check one): 0.3 mg 0.15 mg

Administer 2nd dose if symptoms do not improve in _____ minutes

Antihistamine: (brand and dose) _____

If Asthmatic: (brand and dose) _____

Student has been instructed and is capable of carrying and self-administering own medication. Yes No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

◇ STEP 2: EMERGENCY CALLS ◇

1. If epinephrine given, **call 911**. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.

2. Parent: _____ Phone Number: _____

3. Emergency contacts: Name/Relationship Phone Number(s)

a. _____ 1) _____ 2) _____

b. _____ 1) _____ 2) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

To be completed by healthcare provider

Student Name: _____ DOB: _____

TRAINED/DELEGATED STAFF MEMBERS

- | | |
|----------|------------|
| 1. _____ | Room _____ |
| 2. _____ | Room _____ |
| 3. _____ | Room _____ |
| 4. _____ | Room _____ |
| 5. _____ | Room _____ |

Self-carry contract on file. Yes No

Medication located in: _____

EpiPen® and EpiPen® Jr.

Expiration date: _____

- Pull off blue activation cap.



- Hold orange tip near outer thigh (through clothing, if needed)
- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Auvi-Q 0.3 mg. and 0.15 mg

Expiration date: _____

- Pull the Auvi-Q™ from the outer case.
- Pull off Red safety guard.
- Place black end against the middle of the outer thigh (through clothing, if needed), then press firmly, and hold in place for 5 seconds.



**Once epinephrine is used, call 911.
Student should remain lying down or in a comfortable position.**

Additional information: _____

