

ALLERGY ACTION PLAN

USE 1 FORM PER CHILD FOR EACH ALLERGEN

Student _____ School _____

DOB _____ Age _____ Weight _____ Grade/Rm _____

Allergy to _____

START DATE: _____ END DATE: _____

- Student has asthma. ☐ Yes ☐ No (If yes, higher chance of severe reaction)
- Student has had anaphylaxis. ☐ Yes ☐ No
- Student may carry epinephrine. ☐ Yes ☐ No (if yes, complete next page)
- Student may give him/herself medicine. ☐ Yes ☐ No (If student refuses/is unable to self-treat, an adult must give medicine.)

Student
Photo

IMPORTANT REMINDER

Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

<p>For Severe Allergy and Anaphylaxis</p> <p>What to look for</p> <p>If child has ANY of these severe symptoms after eating the food or having a sting, give epinephrine.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Skin color is pale or has a bluish color <input type="checkbox"/> Weak pulse <input type="checkbox"/> Fainting or dizziness <input type="checkbox"/> Tight or hoarse throat <input type="checkbox"/> Trouble breathing or swallowing <input type="checkbox"/> Swelling of lips or tongue that bother breathing <input type="checkbox"/> Vomiting or diarrhea (if severe or combined with other symptoms) <input type="checkbox"/> Many hives or redness over body <input type="checkbox"/> Feeling of "doom," confusion, altered consciousness, or agitation <p><input type="checkbox"/> SPECIAL SITUATION: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____ . Even if child has MILD symptoms after a sting or eating these foods, give epinephrine.</p>	<p>Give epinephrine!</p> <p>What to do</p> <ol style="list-style-type: none"> Inject epinephrine right away! Note time when epinephrine was given. Call 911. <ul style="list-style-type: none"> <input type="checkbox"/> Ask for ambulance with epinephrine. <input type="checkbox"/> Tell rescue squad when epinephrine was given. Stay with child and: <ul style="list-style-type: none"> <input type="checkbox"/> Call parents and child's doctor. <input type="checkbox"/> Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes. <input type="checkbox"/> Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine. <ul style="list-style-type: none"> <input type="checkbox"/> Antihistamine <input type="checkbox"/> Inhaler/bronchodilator
<p>For Mild Allergic Reaction</p> <p>What to look for</p> <p>If child has had any mild symptoms, monitor child.</p> <p>Symptoms may include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Itchy nose, sneezing, itchy mouth <input type="checkbox"/> A few hives <input type="checkbox"/> Mild stomach nausea or discomfort 	<p>Monitor child</p> <p>What to do</p> <p>Stay with child and:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Watch child closely. <input type="checkbox"/> Give antihistamine (if prescribed). <input type="checkbox"/> Call parents and child's doctor. <input type="checkbox"/> If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis")

Medication/Doses

Epinephrine autoinjector, intramuscular (list type): _____ Dose: ☐ 0.15 mg ☐ 0.30 mg

Antihistamine, by mouth (type and dose): _____

Other (for example, inhaler/bronchodilator if student has asthma): _____

Parent/Guardian Authorization Signature	Date	Physician/HCP Authorization Signature	Date
Emergency Contacts/Relationship		Telephone number	
1. _____		_____	
2. _____		_____	
3. _____		_____	

***** (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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