Picture

**Severe Allergy Action Plan**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIC TO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Asthmatic Yes\* No \*Higher risk for severe reaction**

STEP 1: TREATMENT (This section to be completed by authorizing physician)

**Symptoms: Give Checked Medications**

**• If exposure to allergen (e.g., sting, food ingested), but has no symptoms**

**MILD SYMPTOMS**

• Mouth Itchy runny nose, sneezing Epinephrine Antihistamine

• Skin A few hives, mild itch Epinephrine Antihistamine

• Gut Mild nausea/discomfort Epinephrine Antihistamine

**SEVERE SYMPTOMS - Potentially Life-Threatening**

• Throat Tightening of throat, hoarseness, hacking cough Epinephrine Antihistamine

• Lung Shortness of breath, repetitive coughing, wheezing Epinephrine Antihistamine

• Heart Weak pulse, faint, blue, dizzy Epinephrine Antihistamine

• Gut Repetitive vomiting, severe diarrhea Epinephrine Antihistamine

• Skin Many hives over body, widespread redness Epinephrine Antihistamine

• Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The severity of symptoms can quickly change. When both Epinephrine and Antihistamine are checked, Epinephrine will be given first. Antihistamine or another med given only if student is alert and able to swallow.

DOSAGE

Epinephrine: Inject intramuscularly (check one) □ Epinephrine 0.15mg □ Epinephrine 0.3 mg

Antihistamine: give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Route \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**Required**) Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s name (printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ This student is both capable and responsible to self-administer the Epinephrine. This student may carry his/her Epinephrine:

Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Parent \_\_\_\_\_\_\_\_\_\_\_

**FOR STAFF ONLY:**

Signing here indicates that the medication review has been completed.

Teacher’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Principal’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_