

Allergy Action Plan

Student's Name: _____ **Birthdate:** _____

Allergy to: Bee Sting Food (specify) _____ Other (specify) _____

? Asthmatic: Yes* No *High risk for severe reaction

SIGNS OF ALLERGIC REACTION (check all that apply to your student)

- | | | |
|--|---|--|
| <input type="checkbox"/> Itching | <input type="checkbox"/> Rash | <input type="checkbox"/> Swelling or redness at sting site |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Itching/swelling lips, tongue, or mouth |
| <input type="checkbox"/> Other (specify) _____ | <input type="checkbox"/> Trouble breathing, swallowing, talking | |

I would rate the severity of my child's allergy as: (please circle one)

Not severe 1 2 3 4 5 Severe

TREATMENT

I request that the following medication be kept in health office and be administered as ordered.

Parent must supply medication. If emergency medications indicated on this plan are not provided---911 will be called as needed.

1. Give Medication: _____ Dose: _____ Route: _____
if symptoms are: _____
2. Give Medication: _____ Dose: _____ Route: _____
if symptoms are: _____
3. **Call 911 (if epi given or if reaction severe or if emergency meds not available).**
4. Call parents or emergency contacts as designated on back of this plan.

Student Signature: _____ **Date** _____

Parent Signature: _____ **Date** _____

Physician Signature: _____ **Date** _____

Required for prescription medications

Does your student carry own epi-pen with them? (Circle One) YES NO

If your child is going on a field trip and has an Epi-pen available at school, what would you like done?

- Notify parent of field trip, and send epi-pen from school with student who has been trained on proper use of Epi-Pen.
- Notify parent of field trip, school nursing staff to train ONE designated school employee to administer Epi Pen if needed.
Send Epi-Pen on field trip with designated employee.

Location of Emergency Medications

In Health Office-Med Cart-Drawer #3

Trained Staff Members

Name _____	Date _____	Initials _____
Name _____	Date _____	Initials _____
Name _____	Date _____	Initials _____
Name _____	Date _____	Initials _____

Date Received in Health Office: _____

Allergy Action Plan

EMERGENCY CONTACTS		
Name:	Relation:	Daytime Phone Number: Cell:
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EPIPEN® AND EPIPEN® JR. DIRECTIONS

1. Pull off gray activation cap.



2. Hold black tip near outer thigh (always apply to thigh).



3. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and taken with you to the Emergency Room. Massage the injection

For children with multiple food allergies, use one form for each food.

