



Allergy Action Plan

Student Name: _____ DOB: _____ Grade/Teacher: _____

Bus Car Walk

Location(s) where Epi-pen is/are stored: Office Backpack On person Coach Other _____

TO BE COMPLETED BY LICENSED HEALTHCARE PROFESSIONAL

SEVERE ALLERGY TO: _____

Other allergies: _____

Specific symptoms student has experienced in past: _____

Date of last reaction: _____

Asthma *Yes* No * High Risk for severe reaction

Yes No Can this student responsibly carry and self-administer EpiPen[®]?

Yes No Student has demonstrated use to LHCP

Student weight: Less than 66 pounds (EpiPen[®], Jr) More than 66 pounds (EpiPen[®])

◆ SIGNS OF AN ALLERGIC REACTION ◆

- **MOUTH** itching, tingling, or swelling of the lips, tongue or mouth
- **THROAT** sense of tightness, itching and/or tightness in the throat, hoarseness, change in voice, hacking cough
- **SKIN** hives, itchy rash, and/or swelling about the face or extremities
- **GUT** nausea, stomachache, abdominal cramps, vomiting, and/or diarrhea
- **LUNG** shortness of breath, repetitive coughing, and/or wheezing
- **HEART** weakness, passing out, "thread" pulse, blueness, pale
- **GENERAL** panic, sudden fatigue, chills, fear of impending doom

◆ FOR MINOR REACTION ◆

1. **IF only** symptom(s) are: _____

THEN give _____

Medication	Dose	Route
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2. Call family or emergency contacts.

3. Observe closely. **If condition worsens, follow steps for MAJOR REACTION below.**

◆ FOR MAJOR REACTION ◆

1. **IF** exposure is suspected and/or symptom(s) are: _____

THEN IMMEDIATELY give: _____

Medication	Dose	Route
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Medication	Dose	Route
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2. **Call 911.** ("A student located at _____ is having a life threatening allergic reaction and an EpiPen[®] has been given.")

3. Call family or emergency contacts.

Possible side effects of above medications to report to licensed health care professional:

Licensed Health Care Professional authorizing administration of above medications:

Signature _____ Date _____

Print name _____ Phone _____

Address _____ Fax _____

Individual Considerations

Bus –Transportation should be alerted to student’s allergy.

- ◆ This student carries EpiPen® on the bus: Yes No
- ◆ EpiPen® can be found in: Backpack Waistpack On Person Other (specify) _____
- ◆ Student will sit at front of the bus: Yes No
- ◆ Other (specify): _____

Field Trip Procedures – EpiPen® should accompany student during any off campus activities.

- ◆ Student should remain with the teacher or parent/guardian during the entire field trip: Yes No
- ◆ Staff members on trip must be trained regarding EpiPen® use and student health care plan (plan must be taken).
- ◆ Other (specify) _____

CLASSROOM –For Food allergy only

- ◆ Student is allowed to eat only the following foods: _____
- Those in manufacturer’s packaging with ingredients listed and determined allergen-safe by the nurse/parent or _____
- Those approved by parent.
- Middle school or high school student will be making his/her own decision.
- Alternative snacks will be provided by parent/guardian to be kept in the classroom.
- Parent/guardian should be advised of any planned parties as early as possible.
- Classroom projects should be reviewed by the teaching staff to avoid specified allergens.
- ◆ Student should have someone accompany him/her in the hallways. Yes No
- ◆ Other (specify): _____

CAFETERIA NO Restrictions

- Student will sit at a specified allergy table.
- Student will sit at the classroom table cleansed according to procedure guidelines prior to student’s arrival and following student’s departure.
- Student will sit at the classroom table at a specified location.
- ◆ Cafeteria manager and hostess should be alerted to the student’s allergy.
- ◆ Other: _____

EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:
3.	Relationship:	Phone:
4.	Relationship:	Phone:

- ◆ I request this medication to be given as ordered by the licensed health care provider.
- ◆ I give Health Services Staff permission to communicate with the medical office about this medication. I understand the medication(s) will not necessarily be given by a school nurse (designated staff will be trained and supervised).
- ◆ Medical/Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- ◆ All medication supplied must come in its originally provided container with instructions as noted above by the licensed health care provider.
- ◆ I request and authorize my child to carry and/or self-administer their medication. _____ Yes _____ No
- ◆ This permission to possess and self-administer an EpiPen® may be revoked by the principal/school nurse if it is determined that your child is not safely and effectively able to self-administer.

Parent/Guardian Signature

Date

School Nurse Signature

Date

Nurse initial: Student demonstrated to the nurse the skill necessary to use the medication and any device(s) necessary to self-administer the medication.

A copy of the Health Care Plan will be kept in the substitute folder and given to all staff members who are involved with the student.