Student Photo

ALLERGY/ANAPHYLAXIS ACTION PLAN

Student Name _____ D.O.B. _____Teacher _____
School Nurse Phone Number
Health Care Provider_____ Preferred Hospital_____
History of Asthma ☐ No ☐ Yes – Higher risk for severe reaction

ALLERGY: **(check appropriate)** To be completed by Health Care Provider

- ☐ **Foods (list):**
- ☐ **Medications (list):**
- ☐ **Latex: Circle: Type 1 (anaphylaxis) Type IV (contact dermatitis)**
- ☐ **Stinging Insects (list):**

RECOGNITION AND TREATMENT

Chart to be completed by Health Care Provider ONLY		**Give CHECKED Medication**	
If food ingested or contact w/ allergen occurs:		EpiPen	Antihistamine
No symptoms noted	☐ Observe for other symptoms		
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut+	Nausea, abdominal cramps, vomiting, diarrhea		
Throat+	Tightening of throat, hoarseness, hacking cough		
Lung+	Shortness of breath, repetitive coughing, wheezing		
Heart+	Thready pulse, low BP, fainting, pale, blueness		
Neuro+	Disorientation, dizziness, loss of conscience		
If reaction is progressive (several of the above areas affected), GIVE:			
The severity of symptoms can quickly change. +Potentially life-threatening			

DOSAGE

Epinephrine: Inject into outer thigh ☐ **EpiPen 0.3 mg** OR ☐ **EpiPen Jr. 0.15 mg** (see reverse for instructions)

Antihistamine: Benadryl _____ mg To be given by mouth *only if able to swallow*.

Other:_____

☐ This child has received instruction in the proper use of the EpiPen. It is my professional opinion that this student **SHOULD** be allowd to carry and use the EpiPen independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the EpiPen is self-administered.

☐ It is my professional opinion that this student **SHOULD NOT** carry the EpiPen.

Health Care Provider Signature _____ Phone: _____ Date _____

EMERGENCY CALLS

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call parents/guardian to notify of reaction, treatment and student's health status.
3. Treat for shock. Prepare to do CPR.
4. Accompany student to ER if no parent/guardians are available.

PREVENTION: Avoidance of allergen is crucial to prevent anaphylaxis. Critical components to prevent life threatening reactions: √ Indicates activity completed by school staff

	Encourage the use of Medic-alert bracelets
	Notify nurse, teacher(s), front office and kitchen staff of known allergies
	Use non-latex gloves and eliminate powdered latex gloves in schools
	Ask parents to provide non-latex personal supplies for latex allergic students
	Post "Latex reduced environment" sign at entrance of building
	Encourage a no-peanut zone in the school cafeteria
	Other:

Side 2: To Be Completed by Parent/Guardian, Student and School

Allergy/Anaphylaxis Action Plan (*continued*) **Student Name**_____ **D.O.B.**_____

Parent/Guardian AUTHORIZATIONS

☐ I want this allergy plan implemented for my child; **I want my child to carry the EpiPen** and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of EpiPen.
☐ I want this plan implemented for my child and I **do not** want my child to self-administer EpiPen.
☐ It is recommended that backup medication be stored with the school/ school nurse in case a student forgets or loses EpiPen and/or antihistamine. The school district is not responsible or liable if backup medication is not provided to the school/ school nurse and student is without medication when medication is needed.

Your signature gives permission for the nurse to contact and receive additional information from your health care provider regarding the allergic condition(s) and the prescribed medication.

Parent/Guardian Signature:_____Phone:_____Date:_____

Student Agreement:
☐ I have been trained in the use of my EpiPen and allergy medication and understand the signs and symptoms for which they are given;
☐ I agree to carry my EpiPen with me at all times;
☐ I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) **IMMEDIATELY** when auto-injector EpiPen (epinephrine) is used;
☐ I will not share my medication with other students or leave my EpiPen unattended;
☐ I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature: _____ Date: _____

☐ Back-up medication is stored at school ☐ Yes ☐ No
Approved by Nurse/Principal Signature: _____ Date: _____

DIRECTIONS FOR EPIPEN® USE
Pull off gray activation cap.
Hold Back tip to outer thigh (apply to thigh **ONLY**).
Press hard into outer thigh until auto-injector mechanism functions. Hold in place for 10 seconds.
Massage the injection site for 10 seconds.
Ones Epipen® is used, call 911/EMS. Take the used EpiPen to the emergency room with you.

STAFF MEMBERS TRAINED

NAME	TITLE	LOCATION/ROOM #	TRAINED BY

EMERGENCY CONTACTS

	NAME	HOME #	WORK #	CELL #
Parent/Guardian				
Parent/Guardian				
Other:				
Other:				

STUDENT ASTHMA
ACTION CARD

ID
Photo

Name: _____ D.O.B. _____ Teacher _____
School Nurse: _____ Phone Number: _____
Health Care Provider Treating Student for Asthma: _____ Ph: _____
Preferred Hospital _____
My Personal Best Peak Flow Reading: _____ **(If Applicable)**

Green Zone: All Clear

- Breathing is easy. No asthma symptoms with activity or rest
- Peak Flow Range: _____ to _____ (80 to 100% of personal best) *If applicable.*
  - **Pre-medicate if needed 10 to 20 minutes before sports, exercise or other strenuous activity.**
  - **Pre-exercise medications listed in #1 below.**

Yellow Zone: Caution

- Cough or wheeze. Chest is tight. Short of breath.
- Peak Flow Range: _____ to _____ (50 to 80% of personal best) *If applicable.*
- Medicate with quick reliever. Give medications as listed below.
- May re-check peak flow in 15 to 20 minutes.
- Student should respond to treatment in 15-20 minutes and return to green zone, if not contact parent.

Red Zone: Emergency Plan

- Call EMS if student has any of the following:
  - ✓ Coughs constantly
  - ✓ No improvement 15-20 minutes after initial treatment with medication
  - ✓ Hard time breathing with some or all of these symptoms of respiratory distress:
    - Chest and neck pulled in with breathing
    - Stooped body posture
    - Struggling or gasping
  - ✓ Trouble with walking or talking due to shortness of breath
  - ✓ Lips or fingernails are grey or blue
  - ✓ Peak flow below: _____ (50% of personal best) *If applicable.*
- Medicate with quick reliever. Give medications as listed below.
- Re-check peak flow in 15 to 20 minutes.
- Student should respond to treatment in 15-20 minutes.
- Contact parent/guardian.

Emergency Asthma Medications – *to be completed by Health Care Provider*

	Name	Amount
1.		
2.		

Health Care Provider AUTHORIZATION:

- This Child has received instruction in the proper use of his/her asthma medications.
- It is my professional opinion that this student ***should/should not*** (circle one) be allowed to carry, store and use his/her asthma medications by him/herself.

Added 10/11
Reviewed 04/2015
Reviewed 09/2019
Reviewed 12/2021

Health Care Provider Signature: _____ Date: _____

Side 2 to be filled out by Patent / Guardian, Student, and School

Side 2: To Be Completed by Parent/Guardian and Student

STUDENT ASTHMA ACTION CARD (*continued)* **Student Name: _____ D.O.B. _____**

DAILY ASTHMA MANAGEMENT PLAN

- **Identify the things which start an asthma episode (If known, check each that applies to the student. These should be excluded in the student's environment as much as possible.)**

o Exercise	o Chalk dust/dust	o Food _____
o Strong odors or fumes	o Carpets in the room	o Molds
o Respiratory infections	o Animals _____	o Latex
o Change in temperature	o Pollens (Spring/Summer/Fall)	o Other _____

- **List all asthma medications taken each day.**

Name	**Amount**	**When to Use**
1.		
2.		
3.		

COMMENTS / SPECIAL INSTRUCTIONS

_____

_____

Added 10/11
Reviewed 04/2015
Reviewed 09/2019
Reviewed 12/2021

AUTHORIZATIONS

P**arent/Guardian:**

- I want this plan to be implemented for my child in school.
- I authorized my child to carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration and/or storage of asthma medications. ☐ Yes ☐ No
- It is recommended that backup medication be stored with the school/ school nurse in case a student forgets or loses inhaler or inhaler is empty. The school district is not responsible or liable if backup medication is not provided to the school/ school nurse and student is without working medication when medication is needed.

Your signature gives permission for the nurse to contact and receive additional information from your health care provider regarding the asthma condition and the prescribed medication.

Parent/Guardian Signature: _____ Date: _____

Student Agreement:

- I understand the signs and symptoms of asthma and when I need to use my asthma medication.
- I agree to carry my medication with me at all times.
- I will not share my or use my asthma medications for any other use than what it is prescribed for.

Student Signature: _____ Date: _____

- Approved by School Nurse/School Principal ☐ Back-up medication is stored at ☐ Yes ☐ No

School Nurse/Principal Signature: _____ Date: _____

Added 10/11
Reviewed 04/2015
Reviewed 09/2019
Reviewed 12/2021