Allergy Action Plan

Student's name: _____

Asthmatic: Yes ___ No ___ Birthdate: _____ Teacher: _____

Allergy to: _____ (student's picture)

Name of Physician _____ Phone: _____

Step 1: Prevention Strategies

Parent to review each item and check all those that apply

- ❑ Keep Epi-Pen in classroom
- ❑ Keep Epi-Pen in Nurse's Office
- ❑ Have extra Epi-Pen on bus
- ❑ Student will carry Epi-Pen
- ❑ Student may self-administer Epi-Pen
- ❑ Use of Medic Alert Bracelet
- ❑ Permission to use student photo for ID purposes
- ❑ Classroom discussion about allergies
- ❑ Have classmates wash hands after eating
- ❑ Use allergen free lunch table
- ❑ Parent will provide "safe snacks"
- ❑ Clean student desks after food events
- ❑ Field Trips: Send medications/copy of action plan
- ❑ Other _____

SIGNS OF AN ALLERGY REACTION

•**MOUTH**	Itching, tingling, or swelling of the lips, tongue, mouth
•**SKIN**	Hives, itchy rash, swelling of the face or extremities
•**GUT**	Nausea, abdominal cramps, vomiting, diarrhea
•**THROAT**	Tightness or sense of itching in the throat, hoarseness
•**LUNG**	Shortness of breath, repetitive coughing, wheezing
•**HEART**	Thready pulse, passing-out, blue/grey color

Step 2: Treatment

(This section to be completed by physician's recommendation)

♦ ♦ ♦FOR MINOR REACTION ♦♦♦

1. Note time.
2. Stay with student and monitor.
3. **IF** the **only** symptom(s) are:_____

THEN give_____ _____ _____
Medication Dose Route

4. Call family or emergency contacts (see other side)
5. Observe closely. If condition is worse after 10 minutes, follow steps for MAJOR REACTION

♦♦♦ FOR MAJOR REACTION ♦♦♦

1. Note time.
2. Stay with student and monitor.
3. **IF** exposure is suspected and/or symptom(s) are: _____

_____

THEN give_____ _____ _____
Medication Dose Route

4. **Call 911** (Say: "A student located at _____is having a life threatening allergic reaction and an Epi-Pen has been given.")
5. Call family/emergency contacts (see other side)
6. Give used Epi-Pen and allergy action plan to emergency medical responders.

(See other side for contact information)

Step 3: Emergency Contacts

Name	Relationship	Phone numbers
_____	_____	1.) _____ 2.) _____
_____	_____	1.) _____ 2.) _____
_____	_____	1.) _____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, AMBULANCE WILL BE CALLED!

Preferred Hospital: _____

Parent/guardian signature: _____ Date _____

Trained Staff Members

Name: _____

Name: _____

Name: _____

If any changes are needed on this Allergy Action Plan through out the school year; it is the parent/guardian's responsibility to contact the school nurse.