

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

- | | |
|--|---|
| <ul style="list-style-type: none"><input type="checkbox"/> Keep Epi-Pen in classroom<input type="checkbox"/> Keep Epi-Pen in Nurse's Office<input type="checkbox"/> Have extra Epi-Pen on bus<input type="checkbox"/> Student will carry Epi-Pen<input type="checkbox"/> Student may self-administer Epi-Pen<input type="checkbox"/> Use of Medic Alert Bracelet<input type="checkbox"/> Permission to use student photo for ID purposes | <ul style="list-style-type: none"><input type="checkbox"/> Classroom discussion about allergies<input type="checkbox"/> Have classmates wash hands after eating<input type="checkbox"/> Use allergen free lunch table<input type="checkbox"/> Parent will provide "safe snacks"<input type="checkbox"/> Clean student desks after food events<input type="checkbox"/> Field Trips: Send medications/copy of action plan<input type="checkbox"/> Other _____ |
|--|---|

SIGNS OF AN ALLERGY REACTION

- | | |
|--|--|
| <ul style="list-style-type: none">•MOUTH•SKIN•GUT•THROAT•LUNG•HEART | <ul style="list-style-type: none">Itching, tingling, or swelling of the lips, tongue, mouthHives, itchy rash, swelling of the face or extremitiesNausea, abdominal cramps, vomiting, diarrheaTightness or sense of itching in the throat, hoarsenessShortness of breath, repetitive coughing, wheezingThready 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
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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
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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.**