CUSD#303
LIFE-THREATENING ALLERGY
ACTION PLAN

Student Name: _____D.O.B: _____Grade:_____

ALLERGY TO: _____

Asthmatic ☐ Yes ☐ No ***Higher risk for severe reaction**

Place Child's Picture Here

♦ STEP 1: TREATMENT ♦

Symptoms	**Give Checked Medication** (To be determined by physician authorizing treatment)
• If exposure to allergen, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
• **Mouth** Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
• **Skin** Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
• **Gut** Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
• **Throat†** Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
• **Lung†** Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
• **Heart†** Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
• **Other†**	☐ Epinephrine ☐ Antihistamine
• If reaction is progressing in several of the above areas DO NOT HESITATE TO GIVE:	☐ Epinephrine ☐ Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: Inject intramuscularly (circle one) EpiPen® EpiPen® Jr.

Antihistamine: Give_____ Dose_____ Route_____

Other: Give_____ Dose _____Route_____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

♦ STEP 2: EMERGENCY CALLS ♦

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Physician:_____ Office Number:_____

3. Parents/Guardian : _____ Home: _____

Mother Cell: _____ Mother Work:_____

Father Cell: _____ Father Work: _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____

****COMPLETE BOTH SIDES****

07/7/2009

LIFE THREATENING NON FOOD ALLERGY
HEALTH CARE PROVIDER ORDERS/EMERGENCY CARE PLAN – Part 2

Individual Considerations:

Bus – Transportation should be alerted to student's allergy Date_____

- This student **MUST** carry EpiPen on bus Yes ☐ No ☐
- Student requires preferential seating on bus Yes ☐ No ☐
- EpiPen can be found in**:** ☐ Backpack ☐ Waist pack ☐ On Person ☐ Other

Field Trip Procedures – EpiPen should accompany student during any school related off campus activities

- Certified staff member on trip must be trained regarding EpiPen use
- Health care plan will be reviewed prior to field trip
- Other_____

Student Considerations:

- Student is able to recognize signs and symptoms of exposure to allergen Yes ☐ No ☐
- Student knows how to access emergency help in the school setting Yes ☐ No ☐
- Other_____

School Environment Considerations:

- _____
- _____

****Student MUST be accompanied to health office if they are suspected of having an allergic reaction****

Parent/Guardian Authorization:

- I request this medication be administered as ordered by the student's licensed health care provider.
- I give Health Services staff permission to communicate with the health care provider about this medication.
- I understand that these medications may be administered by certified staff members who have been trained in the administration of emergency medication.
- I agree that this medical information may be shared with school staff working with my child and 911 staff if needed.
- I assume responsibility for supplying medication to the school that will not expire during the course of its intended use. **Expired medication can not be administered!**
- Medication must be in the original prescription container with instructions as noted by above health care provider.
- I will provide an additional EpiPen in the health office if my child is authorized to self-carry.
- In the event of an emergency, I give my permission for transport and treatment at the nearest medical facility.

Health Care Provider's Signature	**Date:**
Parent/Guardian Signature	**Date:**
Certified School Nurse Signature	**Date:**

****COMPLETE BOTH SIDES****