Allergy Action Plan – School Year 2018-2019

This form must be completed by a physician and signed by the parent annually.

Place Student's Picture Here

Name: _____ **D.O.B.:** ____/__/____

Allergy to: _____

Weight: _____lbs. **Asthma:** ❑ Yes (higher risk for a severe reaction) ❑ No

Extremely reactive to the following foods: _____

THEREFORE:

❑ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

❑ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Obstructive swelling (tongue and/or lips)
- SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

- SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
- GUT: Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   - -Antihistamine
   - -Inhaler (bronchodilator) if asthmatic

Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE **EPINEPHRINE**

MEDICATION & DOSAGE:

EPINEPHRINE: **Inject intramuscularly:** (circle one) Epinephrine dose **0.3mg** Epinephrine dose **0.15mg**

Epinephrine may be repeated in _____minutes by School Nurse only.

ANTIHISTAMINE: Diphenhydramine PO: _____mg other: _____

Check all that apply:

_____ Student is **NOT** capable of self-administration

_____ Student has been trained and **is capable of self-administration and may self-carry in school/school-sponsored events**

_____ Student may carry and self administer one (1) prescribed, pre-measured dose of antihistamine.

_____ Student is aware that he/she must report any suspected exposure to allergen, any signs of allergic reaction and use of prescribed medication immediately.

PLEASE NOTE: In the absence of a school nurse, if available, a trained delegate will give 1st dose of epinephrine. Delegate MAY NOT administer antihistamine. IF NO NURSE OR DELEGATE, 911 WILL BE CALLED IMMEDIATELY.

Trained Delegate(s): ***On Reverse Side***

Monitoring: ***Stay with student; alert healthcare professionals and parent.*** **Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.**

_____ _____ _____ _____

Parent/Guardian Signature **Date** **Healthcare Provider Signature/Stamp** **Date**

Cranford Public Schools

Parental Consent for Administration of Epinephrine

I permit the following designated person(s) to administer Epinephrine, in an emergency, to my child in the absence of the school nurse: Please note the delegates are subject to change.

TBA

LOCATION OF EPINEPHRINE:

_____ With Student

_____ With Nurse

_____ Other

Legal Statement from the Cranford Board of Education:

I/We expressly grant the Cranford Board of Education school nurses or designee(s) with the authority to administer epinephrine to the named student via a pre-filled auto-injector mechanism. I/We hereby acknowledge and understand that upon following Board protocol the Cranford Board of Education its employees and agents shall have no liability as a result of any injury arising from the administration of epinephrine in a pre-filled auto-injector mechanism by the school nurse or designee(s) to the named student. I/We acknowledge and understand that the Cranford Board of Education, its employees and agents shall be indemnified and held harmless against any and all claims arising out of the administration of epinephrine in a pre-filled auto injector mechanism to the named student, including but not limited to all liability for any injuries that may result from the administration of such medication. I/We acknowledge and understand that the Cranford Board of Education, its employees, and agents shall be indemnified and held harmless against any and all claims arising out of the named student's self-administration of epinephrine in a pre-filled auto-injector mechanism, including but not limited to all liability for any injuries that may result from the administration of such medication.

Parent Signature: _____ Date: _____

Print Name: _____

Emergency Contact Information:

Doctor Phone: _____ Parent Home Phone: _____

Mother Work Phone: _____ Cell Phone: _____

Father Work Phone: _____Cell Phone: _____

Other Emergency Contact: Name: _____Phone: _____

REV: 3/2015