**Allergy Action Plan**

Student's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergy to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthmatic: Yes\*\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_ \*High risk for severe reaction

Student has received instructions in, and is capable of performing, self-administration: Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_

# **\*\*Signs of Allergic Reaction**

|  |  |
| --- | --- |
| Systems: | Symptoms: |
| -MOUTH | itching & swelling of the lips tongue, or mouth |
| THROAT | itching and/or a sense of tightness in the throat, hoarseness, and hacking cough |
| -SKIN | hives, itchy rash, and/or swelling about the face or extremities |
| -GUT | nausea, abdominal cramps, vomiting, and/or diarrhea |
| -LUNG | shortness of breath, repetitive coughing and/or wheezing |
| -HEART | thready pulse, or "passing out" |

**The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation.**

**\* ACTION FOR MINOR REACTION**

1. If only symptoms(s) are: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(MEDICATION/DOSE/ROUTE)

1. Call Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or emergency contacts.
2. Call Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**If condition does not improve within 10 minutes, follow steps for Major Reaction below**.

**\* ACTION FOR MAJOR REACTION \***

1. If ingestion is suspected and/or symptoms(s) are: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ immediately

(MEDICATION/DOSE/ROUTE)

1. Call Rescue Squad (ask for advanced life support)
2. Call Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or emergency contact.
3. Call Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO NOT HESITATE TO CALL RESCUE SQUAD**

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Stamp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the event the school nurse is unavailable to administer the prescribed epinephrine auto-injector, I consent to it being administered by a designee trained by the school nurse. I acknowledge that the District shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector mechanism to my child and shall indemnify and hold harmless the District and its employees or agents against any claims arising from the administration and/or self-administration of the epinephrine via a pre-filled auto-injector mechanism to my child.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_