**Allergic Reaction/Food Allergy Action Plan**

Student: D.O.B.:

Parent/Guardian: Phone:

Physician: Phone:

Significant Medical History:

Allergy to:

Asthma: □Yes □No

Allergy Reaction was caused when substance was: □Ingested (eaten) □Contacted (touched) □Inhaled

Describe what happened (list symptoms):

Was an emergency injection used for the allergy reaction? If so, when?

Was student treated in an ER or hospitalized for an allergy reaction? If so, when?

Do you take any special precautions to reduce student’s risk of an allergy reaction?

|  |  |
| --- | --- |
| **Mild**  | **Severe** |
| Symptoms* Mouth: itchy mouth
* Skin: a few hives, mild itch
* Abdomen: mild nausea/discomfort
* Nose: itchy/runny nose, sneezing
 | Symptoms* Mouth: significant swelling of tongue and/or lips
* Throat: tight, hoarse, trouble breathing/swallowing
* Skin: many hives over body, widespread redness
* Abdomen: repetitive vomiting, severe diarrhea
* Lung: short of breath, wheeze, repetitive cough
* Heart: pale, blue, faint, weak pulse, dizzy
* Other: anxiety, confusion, feels something bad is about to happen
 |
| Treatment* Give antihistamine
* Stay with student: alert nurse/parents
* Watch closely for changes
* Begin monitoring (see box below)
* Follow physician action plan if on file
 | Treatment* Inject Epinephrine immediately
* Call 911
* Consider giving additional medication following Epinephrine: antihistamine and/or inhaler
* Call parent/guardian
* Follow physician action plan if on file
 |

**Monitoring**:

Lay the person flat, raise legs and keep warm. If breathing is difficulty or they are vomiting, let them sit up or lie on their side. If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose. Alert emergency contacts.

**Emergency Phone Numbers**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Relationship | Cell | Work | Home |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| **EMERGENCY ACTION PLAN AND MEDICATION AUTHORIZATION**FOR KNOWN OR SUSPECTED SEVERE ALLERGY REACTION/ANAPHYLAXIS:•Give Epinephrine intramuscularly (Physician: check one) □EpiPen 0.3 mg □EpiPen Jr. 0.15mg □Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_•For mild allergy reactions (skin rash only) or in addition to Epinephrine injection give: Antihistamine:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Route:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Permission is granted for designated school personnel to administer above medication to student as prescribed by student’s physician.Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent/Guardian Signature\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*My signature indicates that I am giving permission for ROISD staff to contact the physician for additional information, if needed. |