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.