EGG HARBOR CITY PUBLIC SCHOOLS

SCHOOL HEALTH SERVICES

Allergy Action Plan

Student Name: _____ **Date of Birth:** _____

ALLERGY TO: _____

History of Asthma: ☐ Yes (Higher risk for severe reaction) ☐ No

SYMPTOMS:		**Give CHECKED medication**
If an exposure to the allergen has occurred, but there are NO symptoms:		☐ Antihistamine ☐ Epinephrine
Mouth:	itching, tingling, or swelling of lips, tongue, mouth	☐ Antihistamine ☐ Epinephrine
Skin:	hives, itchy rash, swelling of the face or extremities	☐ Antihistamine ☐ Epinephrine
♦ Gut:	nausea, abdominal cramps, vomiting, diarrhea	☐ Antihistamine ☐ Epinephrine
♦ Throat:	tightening of throat, hoarseness, hacking cough	☐ Antihistamine ☐ Epinephrine
♦ Lung:	shortness of breath, repetitive cough, wheezing	☐ Antihistamine ☐ Epinephrine
♦ Heart:	weak or thread pulse, low blood pressure, fainting, pale, blueness	☐ Antihistamine ☐ Epinephrine
Other symptoms:		☐ Antihistamine ☐ Epinephrine
If reaction is progressing (several of the above areas affected):		☐ Antihistamine ☐ Epinephrine

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

DOSAGE:

Epinephrine: inject intramuscularly

☐ EpiPen® ☐ EpiPen® Jr. ☐ Twinject® 0.3 mg ☐ Twinject® 0.15 mg

Antihistamine: *(medication/dose/route)* _____

Other: *(medication/dose/route)* _____

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

Physician Signature: _____ **Date:** _____

EVEN IF PARENT CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR HAVE CHILD TRANSPORTED TO A MEDICAL FACILITY.

EMERGENCY CALLS:

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Doctor: _____ Phone Number: _____
3. Parent: _____ Phone Number: _____
4. Other Emergency Contacts:
   _____ Phone Number: _____
   _____ Phone Number: _____

I acknowledge that it may be necessary for the administration of epinephrine to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and I agree to indemnify and hold harmless the School District and its employees and agents against any claims. I agree to the terms of the procedures for the administration of medication. I further completely release Egg Harbor City Public School District and its employees and agents of any liability or obligation of any nature in any way related to the administration of medication.

Parent/Guardian Signature: _____ **Date:** _____

PLEASE COMPLETE NEXT PAGE

Student Name: _____

MONITORING:

Stay with student; alert healthcare professionals and parent.

Tell rescue squad epinephrine was given. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first dose, if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.

TO BE COMPLETED BY PARENT/GUARDIAN:

I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and I agree to indemnify and hold harmless the School District and its employees and agents against any claims. I agree to the terms of the procedures for the administration of medication. I further completely release Egg Harbor City Public School District and its employees and agents of any liability or obligation of any nature in any way related to the administration of medication. I also understand that my signature on this form denotes permission for the school nurse and the prescribing physician to confer regarding the administration/monitoring of this medication.

Parent/Guardian Signature: _____ **Date:** _____