EMERGENCY ALLERGY ACTION PLAN

School Name _____

Student Name	Date of Birth
*Health Care Provider Name/Title	Provider's Office Phone / FAX #
Parent/Guardian	Parent's Phone #s
Emergency Contact	Contact Phone #s

Known Life-Threatening Allergies:

Diagnosis of Mild Allergy? ☐ No ☐ Yes

Please list allergens:

**History of Asthma? ☐ No ☐ Yes

(*Asthma may indicate an increased risk of severe reaction*)

**History of SEVERE Anaphylactic Reaction? ☐ No ☐ Yes,

If checked **YES**, give epinephrine immediately!
Give epinephrine if allergen was ***likely*** eaten, at onset of ***any*** symptoms or if allergen was **definitely** eaten even if **no** symptoms are noticed.

TREATMENT PLAN

FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:

LUNG: Difficulty breathing or swallowing, wheezing, coughing
HEART: Dizzy, faint, confused, pale, blue, weak pulse
THROAT: Tight, hoarse, trouble breathing/swallowing, drooling
MOUTH: Significant swelling of tongue, lips
SKIN: Many hives over body, widespread redness over body
GUT: Nausea, repetitive vomiting, severe diarrhea, cramping
Other: Feeling something bad is about to happen, anxiety, confusion

OR

A combination of mild symptoms from different body areas

FOLLOW THIS PROTOCOL:

1. ****INJECT EPINEPHRINE IMMEDIATELY!** (Note time)
2. **Call 911.** Request ambulance with epinephrine.
3. Don't hang up & don't leave student
4. Give additional medications as ordered
   - Antihistamine (if ordered below)
   - Inhaler (Albuterol) if student has asthma
5. Lay student flat and raise legs. If breathing is difficult or vomiting, sit up or lie on their side
6. Notify School Nurse and Parent/Guardian
7. Notify Prescribing Provider / PCP
8. Student must be transported to ER

☐ **MILD ALLERGY SYMPTOMS (IF DIAGNOSIS CONFIRMED ABOVE):**

MOUTH: Itchy mouth, lips, tongue and/or throat
SKIN: A few hives, mild itch
NOSE: Itchy/runny nose
GUT: Mild nausea/discomfort

1. GIVE ANTIHISTAMINE (as ordered below)
2. Stay with student; alert emergency contacts
3. Watch student closely for changes
- If symptoms worsen, GIVE EPINEPHRINE
- For mild symptoms from more than one body area GIVE EPINEPRHINE (see above).
4. Notify school nurse.

➢ **THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL SYMPTOMS OF ANAPHYLAXIS CAN POTENTIALLY PROGRESS TO A LIFE THREATENING SITUATION!!**

MEDICATION ORDER

Epinephrine
Student's weight

☐ **Epinephrine (0.15mg)** inject intramuscularly
Epi Pen Auvi Q Adrenaclick

☐ **Epinephrine (0.3mg)** inject intramuscularly
Epi Pen Auvi Q Adrenaclick

Antihistamine
Do not depend on antihistamines (or inhalers). ***When in doubt, give epinephrine and call 911.***

☐ Benadryl/Diphenhydramine
Dose:
Route: PO
Frequency:

☐Other _____
Dose:
Route:

SIDE EFFECTS OF EPINEPHRINE MAY INCLUDE:
ANXIETY, TREMOR, PALPITATIONS, DIZZINESS, WEAKNESS, TINGLING, & PALENESS

NOTE: IF NURSE IS NOT AVAILABLE, THE ABOVE TREATMENT PLAN MAY BE PROVIDED BY TRAINED SCHOOL PERSONNEL FOR ANY ANAPHYLAXIS SYMPTOMS.

MUST BE COMPLETED BY HEALTHCARE PROVIDER, PARENT, AND SCHOOL NURSE

AUTHORIZATION

***Prescriber's Signature:** _____ **Date:** _____

Printed Name: _____ **Phone:** _____

Yes

Parent/Guardian Consent: I have received, reviewed and understand the above information. I approve of this Allergy Action Plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary. I assume full responsibility for providing the school with the prescribed medications. I give my permission for the school to share the above information with school staff that need to know about my child's condition.

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

School Nurse:

I have reviewed this order and completed the allergy emergency care plan and shared with trained school personnel.

_____
Signature / Date

Medication Expires on:

_____