

Allergy and Anaphylaxis Action Plan and Medication Orders

Student's Name: _____ D.O.B. _____ Grade: _____

School: _____ Teacher: _____

ALLERGY TO: _____

History: _____

Asthma: YES (Higher risk for severe reaction) NO

◇ STEP 1: TREATMENT ◇

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Obstructive swelling (tongue and/or lips)
- SKIN: Many hives over body

Or combination of symptoms from different body areas:

- SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
- GUT: Vomiting, crampy pain



1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
 - Antihistamine
 - Inhaler (quick relief) if asthma

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE

MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort



1. GIVE ANTIHISTAMINE

2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

DOSAGE

Epinephrine: inject intramuscularly using autoinjector (check one): 0.3 mg 0.15 mg

Administer 2nd dose if symptoms do not improve in _____ minutes

Antihistamine: (brand and dose) _____

If Asthmatic: (brand and dose) _____

Student's condition warrants accommodations from food service (please complete the bottom of the back page)

Student has been instructed and is capable of carrying and self administering own medication. Yes No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

◇ STEP 2: EMERGENCY CALLS ◇

1. If epinephrine given, call 911. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.

2. Parent: _____ Phone Number: _____

3. Emergency contacts: Name/Relationship _____ Phone Number(s) _____

a. _____ 1) _____ 2) _____

b. _____ 1) _____ 2) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: _____

Date: _____

School Nurse: _____

Date: FAX: 720 274 2056

To be completed by healthcare provider

Place child's photo here