Hopewell Valley Regional School District
Division of Pupil Services
425 South Main Street
Pennington, NJ 08534

Photo of Student

INSECT / FOOD ALLERGY ACTION PLAN

Child's Name ______________________ Birth date ____________ Teacher / Grade ____________

Allergy: ____

Asthmatic? YES * NO * Higher risk of severe reaction Previous episode of anaphylaxis? YES NO

Location of epinephrine ____

MEDICATION TO BE GIVEN

Symptoms		**Give Circled Medication** (to be determined by MD)	
• If a sting / food allergen has been ingested, but no symptoms		Epinephrine	Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine	Antihistamine
• Skin	Hives, itchy rash, swelling of face or extremities	Epinephrine	Antihistamine
• Abdomen	Nausea, cramps, vomiting, diarrhea	Epinephrine	Antihistamine
• Throat †	Tightening of throat, hoarseness, hacking, cough	Epinephrine	Antihistamine
• Lung †	Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
• Heart †	Thready pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
• Other †	______________________	Epinephrine	Antihistamine
• If reaction is progressing (several of the above areas are affected)		Epinephrine	Antihistamine

† **Potentially life-threatening**

MEDICATION AND DOSAGE

Epinephrine (circle one): EpiPen® EpiPen® Jr. Other ____________
(inject intramuscularly into outer thigh)

* **Antihistamine**: Give ____
Medication / Dose / Route

* **<u>When a nurse is not present</u>, I authorize a trained designee to disregard any antihistamine order and to administer <u>epinephrine only</u>.**

SELF-ADMINISTRATION OF MEDICATION (please check)

________ This student has been trained and is capable of self-administration of the following medication(s):

_____ Epinephrine – single dose unit _____ Epinephrine & antihistamine – single dose unit

** Under NJ State law, orders for antihistamine alone cannot be self-administered.*

________ This student is **<u>not</u>** capable of self-administration of the medications named above.

I (parent/guardian) also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medicatons.

______________________ ____________ ____________
Physician Signature **(required)** Telephone Date

______________________ ____________
Parent / Guardian Signature Date