Allergy Action Plan
(Food, Sting, or other Allergen)

Student's Name: ___________________________ Program:_______ Allergic to: ______________________

Asthmatic: _____ yes* ______ no (* Higher risk for severe reaction)

This child last had an allergic reaction to_________________________________ on (date) ______________ that presented as: ____
____

SIGNS OF AN ALLERGIC REACTION

System	Symptoms
MOUTH	ITCHING, TINGLING AND/OR SWELLING OF LIPS, TONGUE, MOUTH
THROAT	ITCHING AND/OR TIGHTNESS IN THE THROAT, HOARSENESS AND COUGH
SKIN	HIVES, ITCHY RASH, AND/OR SWELLING OF THE FACE OR EXTREMITIES
GUT	NAUSEA, ABDOMINAL CRAMPS, VOMITING AND/OR DIARRHEA
LUNGS	SHORTNESS OF BREATH, REPETITIVE COUGHING AND/OR WHEEZING
HEART	WEAK OR "THREADY" PULSE, LOW BLOOD PRESSURE, FAINTING, PALE, BLUENESS

The severity of symptoms can quickly change. ***Do not sent students to the office alone. Call office/333 for assistance as soon as possible. If epinephrine (EpiPen) is needed and student self-carries, administer medication and then call.***

STEP 1: GIVE TREATMENT AS FOLLOWS

MINOR REACTION

If symptoms are: ____

1. **Give** ____
(Medication/Dose/Route of Administration – as directed on the attached Medication Request Form)
2. **Notify** parent/guardian or other emergency contact.

MAJOR REACTION

If symptoms are: ____

1. **Give** ____IMMEDIATELY!
(Medication (s)/ Dose/ Route of Administration – as directed on the attached Medication Request Form)
2. **Call 911.** Call 333 and state that an allergic reaction has been (or needs to be) treated.
3. Notify parents, or emergency contacts and physician.

Emergency Contact Information

Name #1:____ Relationship ______________________________

Home phone: ___________________Work Phone: _________________ Cell Phone: _________________

Name #2:____ Relationship ______________________________

Home phone: ___________________Work Phone: ____________________Cell Phone: _________________

Physician Name: ____

Phone: _________________________________ Fax: ____________________________

Physician's Signature: ____ Date: ______________

Parent/Guardian Signature: ____Date: ______________

The completed Allergy Action Plan will be on file with the school nurse and a copy will be given to your child's teachers, as necessary.

EpiPen Administration Instructions:

Your EpiPen and EpiPen Jr Auto-Injector

EpiPen Auto-Injector (yellow label) in Carrier Tube

EpiPen Auto-Injector (yellow label) removed from Carrier Tube

EpiPen Jr Auto-Injector (green label) in Carrier Tube

EpiPen Jr Auto-Injector (green label) removed from Carrier Tube

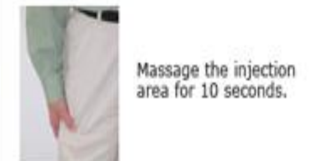
Flip open the yellow cap of your EpiPen or the green cap of your EpiPen Jr Auto-Injector carrier tube.

Tip and slide the auto-injector out of the carrier tube.

Grasp the auto-injector in your fist with the orange tip pointing downward.

With your other hand, **remove the blue safety release by pulling straight up without bending or twisting it.**

Finalize the Injection Process



STAFF NOTE: Once EpiPen is used, call the Rescue Squad (911). Give the used EpiPen auto-injector to the EMS staff.

PARENT NOTE: For children with multiple food allergies, consider providing a separate Action Plan for different allergens. **If an EpiPen is prescribed and student self-carries, a SECOND backup pen MUST be in the possession of the school nurse as by law in Ohio Revised Code Sec. 3313.718.**