ALLERGY ACTION PLAN

USE 1 FORM PER CHILD FOR EACH ALLERGEN

Student _____

DOB _____ Teacher _____

Allergy to _____

Asthmatic? ☐ Yes* ☐ No *Higher risk for severe reaction

STEP 1 - TREATMENT

SEND STUDENT TO HEALTH OFFICE ACCOMPANIED BY RESPONSIBLE PERSON.

The severity of symptoms can quickly change. †Potentially life threatening.

Symptoms

Give checked Medication**

***To be determined by physician authorizing treatment*

- If a student has been exposed to/ingested an allergen but has NO symptoms: ☐ Epinephrine ☐ Antihistamine
- Mouth Itching, tingling, or swelling of lips, tongue, mouth: ☐ Epinephrine ☐ Antihistamine
- Skin Hives, itchy rash, swelling of the face or extremities: ☐ Epinephrine ☐ Antihistamine
- Gut Nausea, abdominal 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 affected), give: ☐ Epinephrine ☐ Antihistamine

MEDICATION: START DATE _____ END DATE _____

Epinephrine: Inject intramuscularly.

Important: *Asthma inhalers and/or antihistamines cannot be depended upon to replace epinephrine in anaphylaxis.*

☐ Epinephrine Autoinjector **0.3mg**

☐ Epinephrine Autoinjector **0.15mg**

Antihistamine: Give _____
antihistamine/dose/route

Other: Give _____
medication/dose/route

Parent/Guardian Signature _____ **Date** _____

Prescriber Name _____ **Phone** _____

Prescriber Signature _____ **Date** _____

STEP 2 - EMERGENCY CALLS

PARAMEDICS (911) MUST BE CALLED IF EPIPEN OR AUVI-Q IS GIVEN. EPIPEN OR AUVI-Q ONLY LAST 15-20 MINUTES.

Call 911. State that an anaphylactic reaction has been treated, type of treatment given (i.e., EpiPen or Auvi-Q) and that additional epinephrine may be needed. Always send empty autoinjector to ER with student. Contact Parent/Guardian.

EVEN IF PARENT/GUARDIAN IS UNAVAILABLE, DO NOT HESITATE TO MEDICATE CHILD & CALL 911

EMERGENCY CONTACTS

	Name	Relationship	Telephone number
1.	_____	_____	_____
2.	_____	_____	_____

****** Form on Page 2 to be completed ONLY if student will be carrying an Epinephrine Autoinjector ******

LETTER TO PARENTS
ALLERGIC REACTIONS

TO: Parents

FROM: Clinic Staff

DATE: _____

SUBJECT: Allergic Reactions

The health care forms you submitted for _____
(Student name)

indicates he/she has an allergic reaction to _____.

In an effort to keep your student safe, please provide the following:

1. The enclosed ALLERGY ACTION PLAN or a similar Emergency Care Plan completed by a licensed prescriber with instructions school staff will follow in the event that your student experiences an allergic reaction while at school.

2. Epinephrine autoinjector(s) if prescribed, and/or other medication to be used if an allergic reaction occurs.

Your prompt attention to this request is appreciated. We would welcome an opportunity to meet with you to discuss your student's allergy and how we will implement the Allergy Action Plan provided . Please contact me at:

_____.

(Please refer to information below regarding permission for your student to self-carry his/her epinephrine autoinjector if authorized by the prescriber.)

Ohio Revised Code (ORC) 3313.718 Possession and use of epinephrine autoinjector to treat anaphylaxis

Effective March 23, 2007, students in Ohio schools will be permitted to carry and use an epinephrine autoinjector with the permission of the prescriber of the medication and the parent/guardian. The law is numbered, Ohio Revised Code (ORC) 3313.718 and applies to any activity, event, or program sponsored by the student's school or in which the school participates. The Epi-Pen law requires:

1) acknowledgment that the prescriber has determined that the student is capable of possessing and using the autoinjector appropriately and has provided the student with training in the proper use of the autoinjector;

2) the school has received a backup dose of the anaphylaxis medication; and

3) whenever an autoinjector is used, a school employee shall immediately request assistance from an emergency medical service provider (e.g., call 9-1-1).

Enclosure

ASTHMA ACTION PLAN

Student Information:

Student: _____ Birthdate: _____

Grade: _____ Homeroom Teacher or Class: _____

Physical Education Days and Times: _____

Emergency Information:

Parent(s) or Guardian(s) _____

Mother: Tel (W) _____ Tel (H) _____

Father: Tel (W) _____ Tel (H) _____

Healthcare Provider _____ Tel _____

In case of emergency, contact:

1. Name _____ Tel _____
2. Name _____ Tel _____

Asthma Emergency Action:

The following are possible signs of an asthma emergency:

- Difficulty breathing, walking, or talking
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms.

These signs indicate the need for emergency medical care. The steps that should be taken:

- Activate the emergency medical system in your area. Call 911.
- Call Parent/Guardian and/or Healthcare Provider

Triggers: _____

Name of Medication	Dosage	Time

Steps for an Acute Asthma Episode (to be completed by physician)

1. _____
2. _____
3. _____
4. _____

Signature of Parent/Guardian _____ **Date** _____

Signature of Prescriber _____ **Date** _____

PLEASE COMPLETE NEXT PAGE FOR PERMISSION TO CARRY INHALER

Parent Request for the Administration of Over-the-Counter Medication by School Personnel

Student Photo

Student _____

Address _____

City / State / Zip _____

Name of Medication _____

Dosage of Medication to be administered (please be very specific)

_____

Times of Day/Intervals or Reasons Medication is to be administered (Please be as specific as possible (i.e. every 4 hours for headache) _____

Date to Begin Medication _____ Date to End Medication _____

Adverse/Severe Reaction that should be reported to parent/guardian _____

Special Instructions for Administration of Medicine _____

This medication can be safely administered by non-medical personnel. ☐ Yes ☐ No

It is NOT possible for a parent/guardian to come to the school to administer this medication. ☐

Please regard my signature below as my assurance that I release Valley Christian School, PSI, and any or all of the school's and PSI's officers or employees from any liability of damages resulting from the consequences or adverse reactions of our child's taking or failure to take this medication at the times prescribed. I also agree to keep the school informed in writing of any changes in medication. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

_____ _____

Parent's Printed Name Telephone #

_____ _____

Parent's Signature Date

PARENT REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL

Student Photo

Student _____

Address _____

City, State Zip _____

Name of Medication and Dosage _____

Times of Day to be Administered _____

Number of Times/Intervals Medication is to be Administered _____

Date to Begin Medication_____ Date to End Medication _____

Adverse/Severe Reaction that should be reported to Physician _____

_____

Special Instructions for Administration of Medication _____

_____

This medication can be safely administered by non-medical personnel. ___ Yes ___ No

It is impossible to arrange for this medication to be taken at home, and therefore it must be administered during school hours. ___ Yes ___ No

This student is under my care. It is not possible to arrange for this medication to be taken at home with the supervision of a parent, and therefore it must be taken during school hours.

_____ _____

Physician's Printed Name Telephone

_____ _____

Physician's Signature Date

Please regard my signature below as my assurance that I release Valley Christian School, P.S.I., and any or all of the school's and P.S.I.'s officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

_____ _____

Parent's Printed Name Telephone

_____ _____

Parent's Signature Date

Ohio Department of Health

Anaphylaxis Emergency Action Plan

Order for Administration Epinephrine Autoinjector in Individuals WITHOUT a Specific Order

SYMPTOMS

For **Any** of the Following **SYMPTOMS**
(Stay with individual. Never leave alone.)
One or more of the following:

LUNG: Short of breath, wheezing, repetitive coughing

HEART: Pale, blue, faint, weak pulse, dizzy, confused

THROAT: Tight, hoarse, trouble breathing and/or swallowing/speaking

MOUTH: Significant swelling of the tongue and/or lips

SKIN: Many hives over body, widespread redness

GUT: Repetitive vomiting, severe diarrhea

NEURO: Feeling something bad is about to happen, anxiety, fear

ACTION STEPS

1. **INJECT EPINEPHRINE AUTOINJECTOR IMMEDIATELY! (See medication/dosage below)**
2. Call EMS (911)
3. Begin monitoring (see box below)
4. Send used autoinjector(s) to emergency department with individual or discard appropriately

MONITORING

Monitoring after 911 is called –Airway, Breathing, and Cardiac.
Stay with individual; alert healthcare professional, principal and parent.
Note:

- ☑ Record time epinephrine autoinjector used and inform rescue squad upon arrival.
- ☑ Continue to keep on back with legs elevated legs above the heart. If difficulty breathing or vomiting present, let individual sit up or lie on side.
- ☑ Provide First Aid/CPR as necessary; AED if necessary and available.

MEDICATION/DOSAGE

Medication/Dosage: Select appropriate epinephrine autoinjector dose, based on weight. If unable to assess weight, use larger dose. Review manufacturer's instructions for specific use of epinephrine autoinjector.

Dosage: ☐ 0.15mg Epinephrine autoinjector IM, if less than 66 pounds
☐ 0.30mg Epinephrine autoinjector IM, if 66 pounds or more
☐ A second epinephrine autoinjector dose can be given 5 or more minutes after the first if symptoms persist or recur.

Additional comments: _____

AUTHORIZED SIGNATURES

Licensed Healthcare Professional Authorized to Prescribe

Name/Title (Printed): _____ Practice Name: _____

Contact Phone Number: _____ Practice Address: _____

Signature: _____ Authorization Dates: Start _____ Stop _____

School Use only:
School Administrator Authorization
Note: Administrator responsible for maintaining list of trained, designated personnel for epinephrine autoinjector

Name/Title (Printed): _____ School Building: _____

Signature: _____ Date: _____

This sample resource is located at the ODH School Nursing website,
http://www.odh.ohio.gov/odhprograms/chss/schnurs/schnurs1.aspx, click on "Forms"

HEA