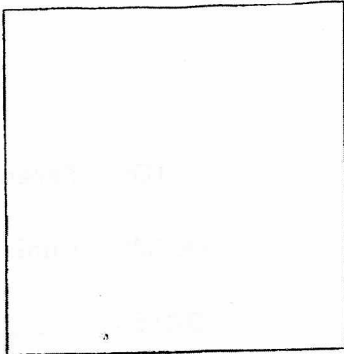


# ALLERGY ACTION PLAN

USE 1 FORM PER CHILD FOR EACH ALLERGEN



Student \_\_\_\_\_  
 Teacher \_\_\_\_\_  
 DOB \_\_\_\_\_  
 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

- ◆ If a student has been exposed to/ingested an allergen but has NO symptoms:
- ◆ Mouth Itching, tingling, or swelling of lips, tongue, mouth:
- ◆ Skin Hives, itchy rash, swelling of the face or extremities:
- ◆ Gut Nausea, abdominal cramps, vomiting, diarrhea:
- ◆ Throat† Tightening of throat, hoarseness, hacking cough:
- ◆ Lung† Shortness of breath, repetitive coughing, wheezing:
- ◆ Heart† Thready pulse, low blood pressure, fainting, pale, blueness:
- ◆ Other† \_\_\_\_\_:
- ◆ If reaction is progressing, (several of the above areas affected), give:

### Give checked Medication\*\*

\*\*To be determined by physician authorizing treatment

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
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| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

**MEDICATION:** START DATE \_\_\_\_\_ END DATE \_\_\_\_\_

Epinephrine: Inject intramuscularly.

- Epinephrine Autoinjector 0.3mg
- Epinephrine Autoinjector 0.15mg

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

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 \_\_\_\_\_

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.

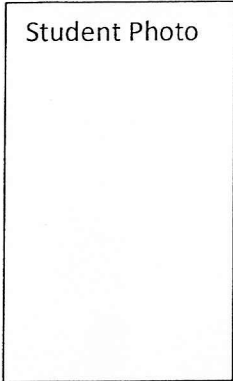
Please regard my signature below as my assurance that I release Valley Christian School, PSI, and any or all of the school's and PSI's officers or employees from any liability of damages resulting from the consequences or adverse reactions of our child's taking or failure to take this medication at the 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

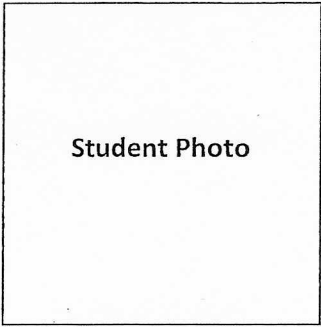
\_\_\_\_\_  
Telephone #

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date



**PARENT REQUEST FOR THE ADMINISTRATION OF  
PRESCRIPTION MEDICATION  
BY SCHOOL PERSONNEL**



Student \_\_\_\_\_

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"