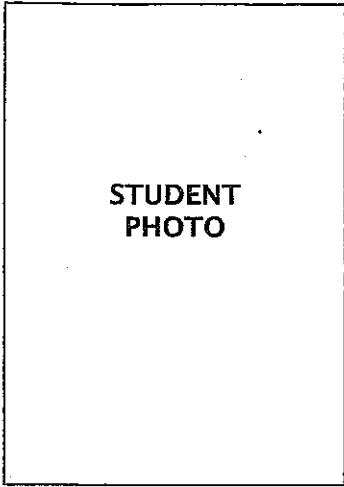


# ALLERGY ACTION PLAN

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: | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ◆ Mouth Itching, tingling, or swelling of lips, tongue, mouth:               | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ◆ Skin Hives, itchy rash, swelling of the face or extremities:               | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ◆ Gut Nausea, abdominal cramps, vomiting, diarrhea:                          | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ◆ Throat† Tightening of throat, hoarseness, hacking cough:                   | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ◆ Lung† Shortness of breath, repetitive coughing, wheezing:                  | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ◆ Heart† Thready pulse, low blood pressure, fainting, pale, blueness:        | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ◆ Other† _____ :   | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ◆ If reaction is progressing, (several of the above areas affected), give:   | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

**DOSAGE**      **START DATE** \_\_\_\_\_      **END DATE** \_\_\_\_\_

**Epinephrine:** Inject intramuscularly. See reverse side for instructions.

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

- EpiPen®
- EpiPen® Jr.
- Twinject 0.3mg
- Twinject 0.15mg

**Antihistamine:** Give \_\_\_\_\_  
*antihistamine/dose/route*

**Other:** Give \_\_\_\_\_  
*medication/dose/route*

**Special Instructions (for health care provider to complete):** \_\_\_\_\_

## STEP 2 - EMERGENCY CALLS

**PARAMEDICS MUST BE CALLED IF EPIPEN OR TWINJECT IS GIVEN. EPIPEN OR TWINJECT ONLY LAST 15-20 MINUTES.**

- Call 911 (or Rescue Squad \_\_\_\_\_). State that an anaphylactic reaction has been treated, type of treatment given (i.e., EpiPen or Twinject) and that additional epinephrine may be needed.
- Parents \_\_\_\_\_ Tel \_\_\_\_\_
- Physician \_\_\_\_\_ Tel \_\_\_\_\_

**EMERGENCY CONTACTS**

1. \_\_\_\_\_  
 Tel: \_\_\_\_\_

2. \_\_\_\_\_  
 Tel: \_\_\_\_\_

3. \_\_\_\_\_  
 Tel: \_\_\_\_\_

Relation: \_\_\_\_\_

Relation: \_\_\_\_\_

Relation: \_\_\_\_\_

**TRAINED STAFF MEMBERS**

1. \_\_\_\_\_

2. \_\_\_\_\_

Room: \_\_\_\_\_

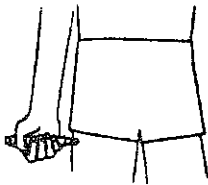
Room: \_\_\_\_\_

**EpiPen® and EpiPen® Jr. Directions**

- Pull off gray activation cap.

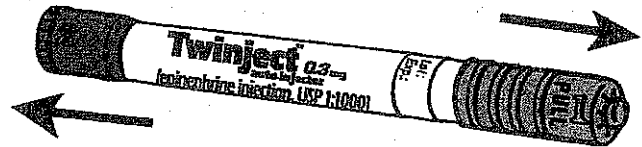


- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

**Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions**



- Pull off green end cap, then red end cap.
- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.



**SECOND DOSE ADMINISTRATION:**  
 If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.



For children with multiple food allergies, use one form for each food.

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

(Required)

# AUTHORIZATION FOR STUDENT POSSESSION AND USE OF AN EPINEPHRINE AUTOINJECTOR

*In accordance with ORC 3313.718/3313.141*

**A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.**

Student name
Student address

**This section must be completed and signed by the medication prescriber.**

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)
Circumstances for use of the epinephrine autoinjector	
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief	

**Possible severe adverse reactions:**

To the student for which it is prescribed (that should be reported to the prescriber)
To a student for which it is <i>not</i> prescribed who receives a dose
Special instructions

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number (     )

**This section must be completed and signed by the student's parent or guardian.**

*As the parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.*

Parent/Guardian signature	Date
Parent/Guardian name	Parent/Guardian emergency telephone number (     )

Source: Ohio Department of Health. Developed in collaboration with the Ohio Association of School Nurses.