Allergy Action Plan

Emergency Care Plan

Name: _____ **D.O.B.:** __/__/__

Allergy to: _____

Weight: _____lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Extremely reactive to the following:_____ _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was ***likely*** eaten/exposed.

☐ If checked, give epinephrine immediately if the allergen was ***definitely*** eaten/exposed, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion/exposure:

One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or combination of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, diarrhea, crampy pain

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

***Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.**

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

1. GIVE ANTIHISTAMINE
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), **USE EPINEPHRINE**
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand & dose) _____

Antihistamine (brand & dose) _____

Other (e.g. inhaler-bronchodilator if asthmatic)_____

Monitoring

Stay with student; alert healthcare professionals and parent. **Tell rescue squad epinephrine was given; request an ambulance with epinephrine.** Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Parent/Guardian Signature _____**Date** _____

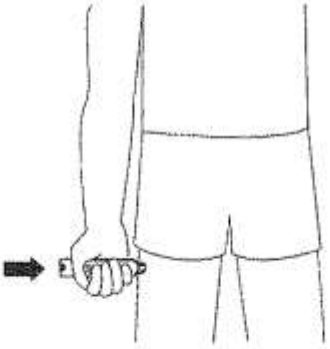
Physician/Healthcare Provider Signature_____ _____**Date**_____

TURN FORM OVER **Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/20/11**

EpiPen Auto-Injector and EpiPen Jr Auto-Injector Directions

- First, remove the EpiPen Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EpiPen Auto-Injector and massage the area for 10 more seconds

EpiPen 2-Pak® | EpiPen Jr 2-Pak®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions

Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___) _____-_____) Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___) _____-_____

Name/Relationship: _____ Phone: (___) _____-_____

PERMISSION TO ADMINISTER MEDICATION

As the parent or legal guardian of _____
I give the staff of the child development center permission to administer this prescribed medication to my child on this date.

Medication_____ Doctor's note: Yes___ No___

Dose_____ Times / Administered by _____ / _____

_____ / _____

_____ / _____

_____ _____

Signature of Parent/Legal Guardian Date

PERMISO PARA ADMINISTRAR MEDICINAS

Como Padre ó Guardián de _____, le doy permiso a los empleados del Centro de Desarrollo de Niño, para administrar esta(s) medicinas recetada(s) a mi hojo(a) en los siguientes días y horas.

Medicina_____ Nota del Doctor: Si___ No___

Dosis_____ Tiempo/Administrada por:_____ / _____

_____ / _____

_____ / _____

_____ _____

Firma del Padre ó Tutor Legal Fecha