**Allergic Reaction Emergency Action Plan**

Student: _____ Date of Birth: _____

Grade: _____ Teacher: _____

Diagnosis of asthma: ❑ No ❑ Yes (associated with higher risk for severe reaction)

**My child's allergic reaction triggers are (please explain):**

| | | | |
|---|---|---|---|
| ❑ Chocolate | ❑ Almond | ❑ Peanut | ❑ Insect sting |
| ❑ Egg | ❑ Brazil Nut | ❑ Pecan | ❑ Latex |
| ❑ Fish | ❑ Cashews | ❑ Pistachio Nut | ❑ Medication (please list) |
| ❑ Fruit (please list) | ❑ Coconut | ❑ Tree nut | |
| ❑ Food additive | ❑ Hazelnut | ❑ Walnut | |
| ❑ Shellfish | ❑ Macadamia | ❑ Seeds (poppy, sunflower, other) | |
| ❑ Vegetable (please list) | | | |

Other (list): _____

Explanation: _____

_____

Place Student's Photo Here

**RECOGNITION AND TREATMENT**

| To be completed by Health Care Provider ONLY | | Give CHECKED Medication | |
|---|---|---|---|
| *If food ingested or contact with allergen occurs:* | | EPINEPHRINE | ANTIHISTAMINE |
| 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, blueish color | | |
| NEURO* | Disorientation, dizziness, loss of consciousness | | |
| If reaction is progressing (several of the above areas affected) GIVE: | | | |
| *** POTENTIALLY LIFE THREATENING** | | | |
| **The severity of symptoms can quickly change.** | | | |

**Epinephrine:** ❑ EpiPen Jr.® ❑ EpiPen® ❑ Twinject® 0.15 mg ❑ Twinject® 0.3 mg

**Antihistamine (Benadryl®)** ❑ 12.5 mg ❑ 25 mg ❑ 50 mg

**Other medication(s):** _____

**EMERGENCY CONTACTS**

| | Name | Home # | Work # | Cell # |
|---|---|---|---|---|
| Parent/Guardian | | | | |
| Parent/Guardian | | | | |
| Other: | | | | |
| Other: | | | | |

**Physician signature:** _____ **Date:** _____

Revised 3/2014

**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**


- Remove caps labeled "1" and "2."
- Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

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

- Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.
- Slide yellow collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.

**Parent/Guardian Agreement and Authorizations**

- ❑ I will provide the school with any medication which my child requires for emergency treatment.
- ❑ I will initiate a meeting with the school nurse and School Nutrition Director to determine menu options for my child who has a food allergy.
- ❑ I will educate my child in self-management of his/her food allergy including safe and unsafe foods, strategies for avoiding exposure to unsafe foods, symptoms of an allergic reaction, and how and when to tell an adult if he/she may be having an allergy related problem.
- ❑ I want this allergy plan implemented for my child; **I want my child to carry an auto-injector** and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self administration of an auto-injector.
- ❑ I want this plan implemented for my child and I **do not** want my child to self-administer epinephrine.

**Your signature gives permission for the school nurse to contact and receive additional information from your health care provider regarding the allergic condition(s) and the prescribed medication.**

Parent/Guardian Signature: _____ Date: _____

**Student Agreement**

- ❑ I have been trained in the use of my auto-injector and allergy medication and understand the signs and symptoms for which they are given.
- ❑ I agree to carry my auto-injector with me at all times.
- ❑ I will notify a responsible adult (teacher, nurse, coach, etc.) **IMMEDIATELY** when my auto-injector is used.
- ❑ I will not share my medication with other students, leave my auto-injector unattended, or use my auto-injector in an inappropriate manner.
- ❑ I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature: _____ Date: _____

Nurse Signature: _____ Date: _____