Allergy Action Plan

TO BE COMPLETED BY PARENT/GUARDIAN

Student:______________________________DOB:__________Grade:_____Date:__________

Emergency Contact (Parent/Guardian):______________________________Phone:_____Phone:__________

Emergency Contact:______________________________Phone:_____Phone:__________

Emergency Contact:______________________________Phone:_____Phone:__________

TO BE COMPLETED BY HEALTHCARE PROVIDER (check treatment below)

ALLERGIC TO:____

☐ ASTHMATIC? **higher risk for severe reaction to allergen*

Symptoms		**Treatment/Medication**		**Dose**
		Antihistamine	Epipen	
If Food allergen ingested...	without symptoms, follow treatment to right >>>			
Skin..........................	itchy rash, hives, swelling of face or extremities			
Mouth........................	itchy, tingling or swelling of lips, mouth & tongue			
Throat........................	hoarseness, hacking cough, tightening of throat			
Lung..........................	repetitive coughing, wheezing, shortness of breath			
Heart..........................	pale, blueness, fainting, thready pulse, low blood pressure			
If reaction is..................	progressing; several of the above areas affected, give			
Other..........................				

***IF Epipen is administered, <u>call 911</u>** & Parent/Guardian. Inform rescue squad that an allergic reaction has been treated and additional epinephrine may be needed. **Even if Parent/Guardian cannot be reached, administer allergy medication and transport child to hospital for follow-up evaluation.**

☐ The school nurse or designated personnel has my permission to administer the above medication(s) in school and/or on class trips, to the student indicated on this form, for this school year only.

☐ The student indicated on this form is capable of carrying and self-administering this medication in school and/or on class trips, has been instructed on the proper procedure, protocol and technique of self-carrying and self-administration and has my endorsement to self-carry and self-administer this medication while in school and/or on class trips, for this school year only.

I acknowledge the school nurse, designated personnel, and school shall incur no liability because of any condition arising from administering of the above medication(s). I indemnify and hold harmless the school and its employees or agents against claims arising from the administration of the above medication(s).

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Healthcare Provider ***{Signature}*** Date

____

Parent/Guardian ***{Signature}*** Date

Healthy Regards,
Michele Avallone (ES), RN, BSN, CSN
Julie Kosylo (ES), RN, BSN, CSN
Sherry Richards (MS/HS), RN, BSN, CSN

**Note that this form is good for <u>one</u> school year! Updated 6/5/17*