Clayton Public Schools

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? Check this box *only* if asthmatic; higher risk for severe reaction to allergen

Systems	**Symptoms**	**Check below those applicable**	
	*The severity of symptoms can quickly change; potentially life-threatening!		
Reaction without symptoms:		Antihistamine Dosage Amt.	Epipen Dosage Amt.
Skin	Itchy, 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		

DOSAGE
Epinephrine give:_____
Specify name of medication, dose, frequency & route

Antihistamine give:_____
Specify name of medication, dose, frequency & route

Other give:_____
Specify name of medication, dose, frequency & route

Even if Parent/Guardian cannot be reached, administer Epipen. Call 911, state an allergic reaction has been treated and additional epinephrine may be needed. Emergency personnel will 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 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).

Healthcare Provider ***{Signature & Stamp}*** Date

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

Healthy Regards,
Michele Avallone, BSN, RN, CSN (ES)
Julie Kosylo, BSN, RN, CSN, (ES)
Sherry L. Richards, BSN, RN, CSN, (MS/HS)
***Note that this form is good for one school year!**
Updated 3/18/21