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).

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*