CUSD#303
LIFE-THREATENING ALLERGY
ACTION PLAN

Student Name:_____ **D.O.B:**_____ **Grade:**_____

Allergy to: _____

Does this student have asthma? ☐ **Yes** ☐ **No** ***Higher risk for severe reaction**

Place Child's Picture Here

☆ STEP 1: TREATMENT ☆

Symptoms	**Give Checked Medication** (To be determined by physician authorizing treatment)
• If exposure to allergen, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
• **Mouth** Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
• **Skin** Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
• **Gut** Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
• **Throat†** Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
• **Lung†** Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
• **Heart†** Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
• **Other†**	☐ Epinephrine ☐ Antihistamine
• **If reaction is progressing in several of the above areas DO NOT HESITATE TO GIVE**	☐ Epinephrine ☐ Antihistamine

†*Potentially life-threatening. The severity of symptoms can quickly change.*

MEDICATION/DOSAGE

Epinephrine (Brand & Dose): _____

Antihistamine (Brand & Dose): _____

Other (e.g., inhaler-bronchodilator if asthma): _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be relied upon to replace epinephrine in anaphylaxis

This student is authorized to self-carry/self-administer an Epinephrine auto-injector **?** ☐ Yes ☐ No

☆ STEP 2: EMERGENCY CALLS ☆

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Licensed Health Care Provider:_____ Office Number: _____

3. Parents/Guardian:_____ Home: _____

Mother Cell:_____ Mother Work: _____

Father Cell:_____ Father Work:_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____ Date_____

Health Care Provider Signature_____ Date_____

****COMPLETE BOTH SIDES****

Individual Life-Threatening Allergy Care Plan

General Plan:

- ☐ Epinephrine will be stored in the: ☐ Nurses Office ☐ Class Room ☐ On Person
- ☐ If applicable, the *Self-Carry/Self-Administer Waiver* form has been signed & submitted.

Field Trip Procedures:

- ☐ Special needs will be identified prior to any off-campus trip.
- ☐ Prescribed medication & Emergency Action Plan must be reviewed and carried by certified staff member.

Other Needs: _____

Parent/Guardian Plan:

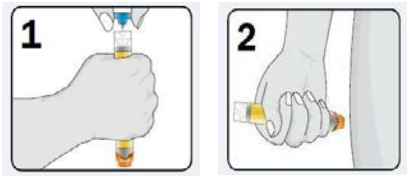
- ☐ I give Health Services staff permission to communicate with the Health Care Provider about this medication.
- ☐ I understand that these medications may be administered by a certified staff member who has reviewed this care plan and the use of emergency medication.
- ☐ I agree that this information will be shared with school staff working with my child and 911 personnel, if needed.
- ☐ I assume responsibility for supplying medication that will not expire during the course of its intended use.
- ☐ I will provide medication in the original prescription container with instructions by above health care provider.
- ☐ If my child is authorized to self-carry, additional medication will be kept in the health office as recommended.

Parent/Guardian Signature: _____ **Date**: _____

Reviewed by School Nurse: _____ **Date:** _____

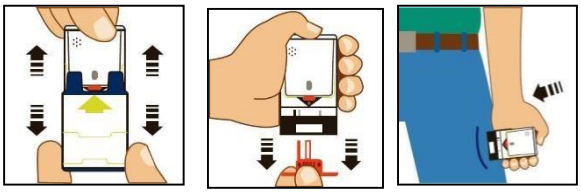
EpiPen (Epinephrine) Auto-injector Directions

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



Auvi-Q (Epinephrine) Injection Directions

1. Remove the outer case of Auvi-Q. This will automatically activate voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



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