

Life Threatening Allergy Emergency Action Plan

ID: _____ Student Name: _____ Birthdate: _____

Teacher/Grade: _____

Parents/Guardians: _____

Contact Information: (H) _____ (C) _____
(W) _____ (C) _____

Physician Name: _____ Physician Phone: _____

Allergy to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

Extremely reactive to the following foods: _____

THEREFORE:

- If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
- If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing MOUTH: Obstructive swelling (tongue and/or lips) SKIN: Many hives over body

Or **combination** of symptoms from different body areas: SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips) GUT: Vomiting, crampy pain



1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
 - Antihistamine
 - Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort



1. GIVE ANTIHISTAMINE

2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medication/Doses

Epinephrine: Brand _____ Dose _____

Antihistamine: Brand _____ Dose _____

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

Self-Administration (Pupil has the discretion as to the use of his/her medication)

() Yes *I certify that the above named student has been instructed in the use and self-administration of _____ . He/she understands the needs for the medication and the necessity to report to school personnel so that 911 can be called.

() No

PHYSICIAN SIGNATURE: _____ DATE: _____

Student Name: _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

To Be Completed By Parent/Guardian

I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self administration of medication. I agree to the terms of the procedures for the administration of medication. I further completely release Community Unit School District 220 and its employees and agents of any liability or obligation of any nature in any way related to the administration of medication. I also understand that my signature on this form denotes permission for the school nurse and the prescribing physician to confer regarding the administration/monitoring of this medication.

Parent/Guardian signature

Date

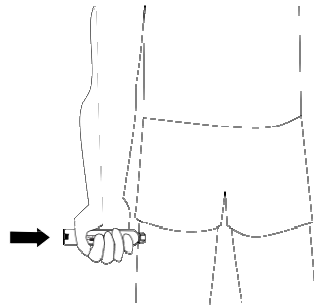
For students who need to carry asthma inhaler, epinephrine auto-injector or insulin: He/she is capable of using this medication independently while in school, while at school sponsored activities, such as in before-school or after-school care on school operated property. If you agree please initial: _____

EPiPEN Auto-injector and EPiPEN Jr Auto-injector Directions

- First, remove the EPiPEN Auto-injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPiPEN Auto-injector and massage the area for 10 more seconds



DEY® and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

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.



Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."



Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: () -) Doctor: _____
 Parent/Guardian: _____

Phone: () - _____
 Phone: () - _____

Other Emergency Contacts

Name/Relationship: _____
 Name/Relationship: _____

Phone: () - _____
 Phone: () - _____