Kyrene School District
Health Services
a division of Supplemental Education

Allergy Action Plan

Student Picture

Student: ______________________________ Date of birth: ________________

Allergy:
____
____

Type of reaction: Anaphylaxis ☐ Other ☐ ____ (please check and initial)

Is student Asthmatic? (*Please circle: YES or NO)*

If student is capable of administering his/her own emergency medication(s) without adult supervision please check box and initial. ☐ _______ (please initial)

Please note that should a student self-administer an emergency medication they are required to notify the school office.

Symptoms (Mild)

Mild skin reactions (hives, swelling only in the areas of allergen contact).

Treatment (Mild)

1. Note time of occurrence and stay with the student
2. Watch closely for any sign of a serious reaction
3. Give (name of medication) ______________________________ as directed by the parent.
4. Call parent/guardian
5. Do not hesitate to call 911 or to give emergency medications if symptoms worsen.

Symptoms (Severe)
If student experiences any or all of these consider this to be a severe reaction:

- Skin — widespread hives and flushing, widespread swelling
- Mouth — swelling of the tongue
- Throat — itching or a sense of tightness in the throat, hoarseness and or hacking cough
- Gut — vomiting, nausea, cramps, diarrhea
- Lungs — repetitive coughing, wheezing, trouble breathing
- Heart — rapid heart rate, lightheadedness, dizziness, loss of consciousness

Treatment (Severe)

1. Note time of occurrence and stay with the student
2. Give: (name of medication(s)) ___________________________ as ordered by the physician.
3. Administer (please circle) EpiPen or Twinject. Follow directions on injection device as trained.
4. Note the time it was given.
5. Call 911 and ask for advance life support for an allergic reaction
6. Give injection device to the emergency responders
7. Give copy of emergency card to the emergency responders
8. Call parent/guardian, or emergency contact and RN
9. Even if parent /guardian or emergency contact can not be reached do not hesitate to call 911

Treatment section to be completed by the physician or parent/guardian

Symptoms:

(To be determined by Physician or Parent/ Guardian)	Give Circled Medication	
If **a food allergen has been ingested, but *no* symptoms**	**Epinephrine**	**Antihistamine**
Mouth (itching, tingling or swelling of the lips, tongue)	**Epinephrine**	**Antihistamine**
Skin (hives, itchy rash, swelling of the face or extremity)	**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 (thready pulse, low blood pressure, fainting, pale or blueness)	**Epinephrine**	**Antihistamine**
Other____	**Epinephrine**	**Antihistamine**
If reaction is progressing (several of the above) give:	**Epinephrine**	**Antihistamine**

Dosage

Epinephrine: inject intramuscularly ***(Circle one)***:

EpiPen (.3 mg), EpiPen Jr. (.15 mg) Twinject (.3 mg) Twinject (.15 mg)

See below for Instructions:

Antihistamine: Give (medication, dose and route) ____

Other: Give (medication, dose and route) ____

My child will be eating food provided by the school cafeteria. (please circle Yes or No)

Parent and Physician (if indicated) please sign below your approvals of this allergy plan

Parent/Guardian signature: __________________________________ Date: _____________

I understand that school staff can and will be informed of my child's health concerns in order to provide safe and appropriate care.

Physician's signature: ______________________________________ Date: _____________

(optional if the physician has not been requested to complete physician's section per parent/guardian request)

TRAINED STAFF MEMBERS

1. ____ Room _______

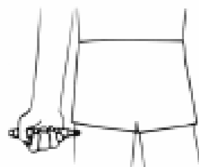
2. ____ Room _______

3. ____ Room _______

EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.

- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

- Pull off green end cap, then red end cap.

- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.

<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.

- Put needle into thigh through skin, push plunger down all the way, and remove.

Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

Name of Student: ________________________________
Date of Birth: ____________________________________
Name of School: ________________________________

Parent's Request for Health Care Procedure(s)

We request the following health care procedure(s) be administered to our child:

____.

The school administrator will designate the staff member(s) who will perform the health care procedure(s) listed above. The person(s) who perform the procedure(s) will do so under the supervision of the site supervisor, e.g., principal.

The individual performing the procedure will be a staff member, not necessarily a licensed nurse. The parent or parent designee will be responsible for training.

____ _______________________
Name of Physician Telephone Number

________________________________ __________________ _____ _________
Street City State Zip Code

We understand that we are responsible for providing and bringing all necessary supplies and equipment, correctly labeled, with proper directions for use at school.

We will notify the Registered Nurse and the school immediately if our child's health status changes, we change physicians, or the procedure(s) is/are changed or canceled. We understand that any change in procedures must be received in writing from the physician listed above.

We understand that, whenever possible, the physical health care procedure(s) should be provided by the parents/guardians before or after school hours. In the event that the principal designee is unavailable to perform the procedure, an attempt will be made to contact the parent and advice will be sought regarding the procedure and/or 911 will be called.

I give my permission for the Kyrene School District Registered Nurse to train the school Health Assistant or designated Staff member in the procedure, should I be unavailable.

____ ______________________
Signature of Parent/Guardian Date

Parent/Guardian's Telephone (work): ____

Parent/Guardian's Telephone (home): ____

Parent/Guardian's Telephone (cell): ____

Parent to Sign and Return Request to Registered Nurse