

# Allergy and Anaphylaxis Action Plan and Medication Orders

Student's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade: \_\_\_\_\_  
 School: \_\_\_\_\_ Teacher: \_\_\_\_\_

Place child's  
photo here

ALLERGY TO: \_\_\_\_\_

History: \_\_\_\_\_

Asthma:  YES (Higher risk for severe reaction)  NO

### ◇ STEP 1: TREATMENT ◇

#### SEVERE SYMPTOMS:

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

Give epinephrine immediately if the allergen was definitely ingested, even if there are no symptoms



1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:\*
  - Antihistamine
  - Inhaler (quick relief) if asthma

\*Antihistamine & quick relief inhalers 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

#### DOSAGE

Epinephrine: inject intramuscularly using auto-injector (check one):  0.3 mg  0.15 mg

Administer 2<sup>nd</sup> dose if symptoms do not improve in \_\_\_\_\_ minutes

Antihistamine: (brand and dose) \_\_\_\_\_

If Asthmatic: (brand and dose) \_\_\_\_\_

Student has been instructed and is capable of carrying and self-administering own medication.  Yes  No

Provider (print) \_\_\_\_\_ Phone Number: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

### ◇ STEP 2: EMERGENCY CALLS ◇

1. If epinephrine given, call 911. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: \_\_\_\_\_ Phone Number: \_\_\_\_\_
3. Emergency contacts: Name/Relationship Phone Number(s)
  - a. \_\_\_\_\_ 1) \_\_\_\_\_ 2) \_\_\_\_\_
  - b. \_\_\_\_\_ 1) \_\_\_\_\_ 2) \_\_\_\_\_

#### EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

To be completed by healthcare provider