

## Severe Allergy Action Plan

Student's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_ Room No. \_\_\_\_\_

### TO BE COMPLETED BY A LICENSED PHYSICIAN

**Allergy to:** \_\_\_\_\_ **Asthma:**  Yes (higher risk for severe reaction)  No

Extremely reactive to the following foods: \_\_\_\_\_

THEREFORE:

If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten

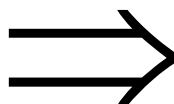
#### Any SEVERE SYMPTOMS after suspected or known ingestion:

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 /swallowing, obstructive swelling (tongue and/or lips)
- SKIN: Many hives over body

Or combination of symptoms from different body areas:

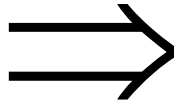
- SKIN: hives itchy rashes, swelling (e.g. eyes, lips)
- GUT: Vomiting, diarrhea, cramping pain



1. INJECT EPINEPHRINE IMMEDIATELY
  2. Call 911
  3. Begin monitoring (see box below)
  4. Give additional medication:\*  
-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)

#### MEDICATIONS/DOSES

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

Exp. Date \_\_\_\_\_

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

Other (e.g., inhaler-bronchodilator is asthmatic): \_\_\_\_\_

#### MONITORING

*Stay with student; alert healthcare professional 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 symptoms persist or recur. For a severe reaction, consider keeping student on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Permission to carry and self-medicate Location of Epi-pen: \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Print Name (Physician) \_\_\_\_\_ Telephone \_\_\_\_\_ Date \_\_\_\_\_

#### Parent Consent for Authorization and Management of Anaphylaxis in School Setting

I (we) undersigned the parent(s)/guardian(s) of the above student, request that the specialized physical healthcare service, anaphylaxis treatment, be administered to my (our) child in accordance with state law and regulations. I (we) will:

1. Provide the necessary supplies and equipment;
2. Notify the school nurse if there is a change in my child's health status or attending authorized healthcare provider; and
3. Notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

Parent(s)/Guardian(s) Printed Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Parent(s)/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Registered Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical Statement to Request Special Meals  
TO BE COMPLETED BY PHYSICIAN IF STUDENT HAS A FOOD ALLERGY**

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Grade:** \_\_\_\_\_  
**School:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Parent/Guardian:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**School Nurse:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Medical Condition Requiring Special Accommodations:**

Severe Allergy to: \_\_\_\_\_

**Provide a Brief Description of Participant's Major Life Activity Affected by the Medical Condition:**

Life threatening food allergy (anaphylaxis) inhibits eating.

**Diet Prescription and/or Accommodation: (Please describe in detail to ensure proper implementation)**

Prohibit student's ingestion of/exposure to: \_\_\_\_\_

**Foods to be Omitted and Substitutions: (Please list specific foods to be omitted and suggested substitutions. You may attach a sheet with additional information)**

A. Foods to Be Omitted

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Suggested Substitutions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature**

\_\_\_\_\_  
**Date**