OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

Oakland Unified School
Health Services Unit

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**