

**GREAT HEARTS ACADEMY – ALLERGY ACTION PLAN** for the 2019/2020 SCHOOL YEAR

CHILD LAST NAME: \_\_\_\_\_  
 FIRST NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
 PARENT/GUARDIAN: \_\_\_\_\_  
 BEST CONTACT PHONE NUMBER: \_\_\_\_\_  
 PHYSICIAN NAME: \_\_\_\_\_  
 PHYSICIAN PHONE NUMBER: \_\_\_\_\_  
 TEACHER: \_\_\_\_\_ ROOM # \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

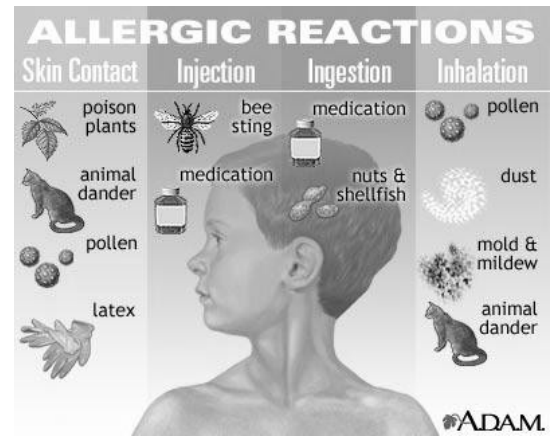
TYPE OF REACTION: \_\_\_\_\_ Anaphylaxis \_\_\_\_\_ Nausea/Vomiting \_\_\_\_\_ Rash

Other reaction: \_\_\_\_\_

Allergic reaction may occur by: \_\_\_\_\_ Ingestion \_\_\_\_\_ Inhalation \_\_\_\_\_ Touch or Other: \_\_\_\_\_

Is the student asthmatic? \_\_\_\_\_ yes \_\_\_\_\_ no

My student will be eating food provided by local vendors for lunch \_\_\_\_\_ yes \_\_\_\_\_ no



My child may exhibit **MILD** symptoms with exposure to allergen \_\_\_\_\_

Treatment of **MILD** symptoms include:

1. Note time and occurrence of symptoms and stay with student
2. Watch closely for any sign of a serious reaction
3. Call parent/guardian listed above or communicate in writing of event
4. Give the following Medication: \_\_\_\_\_ Given to nurse \_\_\_\_\_ yes \_\_\_\_\_ date  
 Dose: \_\_\_\_\_  
 May repeat: \_\_\_\_\_  
 Other instructions: \_\_\_\_\_
5. Call 911 or give emergency medications if symptoms worsen

My child may exhibit **SEVERE** symptoms with exposure to allergen \_\_\_\_\_

*(Exhibiting any or all of the following symptoms is considered to be a severe allergic reaction: widespread hives and flushing, widespread tissue swelling, swelling of the tongue, throat itching or a sense of tightness in the throat, hoarseness and/or hacking cough, vomiting, nausea, cramps, diarrhea, repetitive coughing, wheezing, trouble breathing, rapid heart rate, lightheadedness, dizziness, loss of consciousness)* Treatment of **SEVERE** symptoms include:

1. Note time and occurrence of symptoms and stay with student
2. Call 9-1-1 and inform them of a severe allergic reaction
3. Administer according to package instructions(circle) EpiPen 0.3 mg intramuscularly Given to nurse \_\_\_\_\_ yes  
 EpiPen Jr. 0.15 mg intramuscularly  
 TwinJect 0.3 mg intramuscularly  
 Twinject 0.15 mg intramuscularly
4. Call parent/guardian listed above, continue monitoring student for return of severe symptoms
5. Give injection device used, packaging, and student information to emergency responders
6. Give the following ANTIHISTAMINE: \_\_\_\_\_ Given to nurse \_\_\_\_\_ yes \_\_\_\_\_ date  
 Dose: \_\_\_\_\_  
 May repeat: \_\_\_\_\_  
 Other instructions: \_\_\_\_\_

I understand that school staff **MUST** be informed of my child's health concerns in order to provide safe and appropriate care. I will update the school nurse office as my child's health conditions/treatments change throughout the year.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Food Allergy Action Plan

## Emergency Care Plan

Place  
Student's  
Picture  
Here

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

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, diarrhea, 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)

### Medications/Doses

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

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

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

### 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.

Parent/ Guardian Signature \_\_\_\_\_

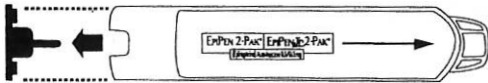
Date \_\_\_\_\_

Physician/Healthcare Provider Signature \_\_\_\_\_

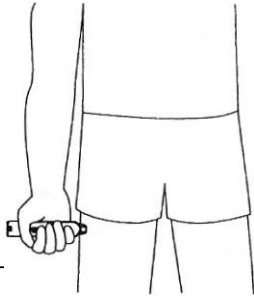
Date \_\_\_\_\_

### 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.

### 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: \_\_\_\_\_ Phone: ( \_\_\_ ) \_\_\_ - \_\_\_ )

Parent/ Guardian: \_\_\_\_\_ Phone: ( \_\_\_ ) \_\_\_ - \_\_\_ )

### Other Emergency Contacts

Name/ Relationship: \_\_\_\_\_ Phone: ( \_\_\_ ) \_\_\_ - \_\_\_ )

Name/ Relationship: \_\_\_\_\_ Phone: ( \_\_\_ ) \_\_\_ - \_\_\_ )