PRINCE GEORGE COUNTY PUBLIC SCHOOLS

Allergy Action Plan

Student's Name: _____ DOB: _____ Weight (pounds):_____

School: _____School Year: _____

ALLERGY TO: _____

Symptoms of Previous Reactions: _____

Does child have asthma? Yes* ☐ No ☐ ***Higher risk for severe reaction if asthmatic**

Symptoms of an Allergic Reaction:	****Give Checked Medication** (to be determined by physician/licensed prescriber)	
• If a food allergen has been ingested, but NO SYMPTOMS	☐Epinephrine	☐Antihistamine
• If stung by a bee, but NO SYMPTOMS	☐Epinephrine	☐Antihistamine
• Mouth Itching, tingling, or swelling of lips, tongue, mouth	☐Epinephrine	☐Antihistamine
• Skin Hives, itchy rash, swelling of face or extremities	☐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 † Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐Epinephrine	☐Antihistamine
• Other † _____	☐Epinephrine	☐Antihistamine
• If a reaction is progressing (several of the above areas affected), give:	☐Epinephrine	☐Antihistamine

† Potentially Life Threatening. The severity of symptoms can quickly change.

TREATMENT AND MEDICATION ORDER:

Epinephrine (Circle Correct Dosage): **EpiPen® (0.3 mg)** **EpiPen Jr.® (0.15 mg)**

If symptoms continue, give second dose 5 to 15 minutes after first dose.

Antihistamine (Medication/Dose/Frequency) _____

Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed. Stay with student until emergency medical services arrive. Monitor airway, breathing, and pulse. Administer CPR if needed. Direct someone to notify parent or guardian. Provide EMS or parent/guardian with used epinephrine auto-injector labeled with name, date, and time given to take to hospital with student.

EMERGENCY CONTACTS: Name/Relationship **Phone Number(s)**

a. _____ 1.) _____ 2.) _____

b. _____ 1.) _____ 2.) _____

c. _____ 1.) _____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE MY CHILD TO MEDICAL FACILITY!

☐ Student has been instructed in the proper use of auto-injectable epinephrine, has demonstrated proper use and may carry his/her own auto-injectable epinephrine at school.

☐ Student should **NOT** carry his/her auto-injectable epinephrine at school.

Parent/Guardian Signature _____ Date _____

Physician/Prescriber Signature _____ Date _____

Physician/Prescriber PRINTED Name_____ Phone_____ FAX_____

Student's Name: _____ School: _____ Teacher: _____

ALLERGY TO: _____

Does student have permission to carry and self-administer his/her own auto-injectable epinephrine? _____YES _____NO
If YES, where does student keep his/her auto-injector?

Plan for lunches and snacks if food allergy:
List foods to be substituted _____
Does parent request separate table (allergen-free area) in the cafeteria? _____YES _____NO
May student purchase food at school and in the cafeteria? _____YES _____NO
Will parent provide snacks for each day? _____YES _____NO for parties? _____YES _____NO
Other:

Plan for field trips:
Will parent attend field trips? _____YES _____NO
In the absence of the parent, the principal's designee, who has been trained by a registered nurse in the administration of epinephrine, will attend the field trip to provide care and administer epinephrine as ordered by licensed prescriber.
Other:

Plan for transportation to and from school:
Epinephrine will **not** be provided on the bus unless student has permission to carry and self-administer auto-injectable epinephrine. Special accommodations shall be considered upon request of parent, guardian or physician. The Office of the Transportation Department is informed of student's allergic condition and has two-way radio communication capability with bus and car drivers.
Other:

Plan for sports and extracurricular activities:
Parent or guardian shall be responsible to inform coach, club sponsor, etc. of child's allergic condition and any required treatment. School nurse will communicate student's allergy health information to coach, club sponsor, etc. upon written request of parent or guardian.
Other:

Plan for communication of allergy information to school staff:
School nurse will communicate information about student's allergic condition and treatment plan to school staff who need to know in order to carry out the plan of care. Teacher shall be responsible to make available the information to substitute teacher.
Other:

Physician Signature: _____

Printed Name: _____

I, _____, parent or legal guardian of _____, request that the principal's designee at _____ School administer the prescribed medication and provide care to my child as indicated on this *Allergy Action Plan*. I give the school nurse, principal, and/or principal's designee permission to contact the licensed prescriber if necessary. In signing this form, I am agreeing to hold the school and its personnel free from any legal action that might arise from this arrangement.

I also understand that I am to abide by the school division regulations as stated below:

- Parent or guardian must bring medication into school. All medication brought to school must be delivered to the office or clinic immediately. Medication cannot be transported on buses or by students.
- Prescription medication must have a current prescription label that corresponds with the written authorization.
- Any changes in an original medication authorization require a new written authorization and corresponding change in the prescription label.
- Parent or guardian is responsible for supplying medications and any equipment required to administer medications or provide special medical care.
- Expired medication will not be administered to students. Parent or guardian is responsible to replace expired medication immediately. Expired medication that has not been picked up by parent or guardian within 2 (two) weeks of notification will be discarded.
- Left over medication that has not been picked up by parent or guardian at the end of the school year will be discarded.

Students with a diagnosis of anaphylaxis (severe allergic reaction) may possess and self-administer auto-injectable epinephrine during the school day, at school-sponsored activities, and while on the bus or other school property provided the following conditions are met:

- ✓ Written consent from a parent and written notice from licensed prescriber that identifies the name, dosage and frequency of medication and circumstances which warrant such medication to be self-administered;
- ✓ Physician confirmation that student demonstrates ability to safely and effectively self administer medication;
- ✓ Individualized health care plan including emergency procedures for any life-threatening conditions (completion of this *Allergy Action Plan* meets such requirement);
- ✓ Permission to possess and self-administer auto-injectable epinephrine shall be effective for one year, defined as 365 calendar days, and must be renewed annually.
- ✓ Parent or guardian will be notified by a school official before any limitations or restrictions are imposed upon a student's possession and self-administration of auto-injectable epinephrine.
- ✓ It is the student's responsibility to notify a teacher or school health official after self administering medication.

I approve this *Allergy Action Plan* for my child. I give permission to share information about my child's allergic condition with the school nurse, teachers, principals, office staff, guidance, bus driver/transportation, cafeteria monitor, and food services as appropriate.

Parent/Guardian Signature _____ Date _____

Parent/Guardian PRINTED Name _____

Home Phone _____ Work Phone _____ Cell Phone _____

School Use:

Health care plan information provided by _____ to the following staff:

Names of Persons and Date	*Names of Persons and Date*
_____	_____
_____	_____
_____	_____
_____	_____