Memo

To: Parents of Children with Severe Allergies

From: Bennett Pallant, M.D., School Physician

Date: September 22, 2010

Re: Allergy Action Plan

All children with severe allergies should have an emergency action plan on file with the school nurse.

In order to eliminate any possible errors in the treatment of your child in what can be a life threatening emergency, we have decided to have a standard form for use with all children.

Please have your child's physician sign the attached form and return it to the school nurse immediately.

If we do not hear from you these will be the orders followed for your child.

Non-Food Severe Allergy Action Plan

Name: _____ D.O.B.: ___/___/___

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Extremely reactive
THEREFORE:
☐ If checked, give epinephrine immediately for ANY symptoms
☐ If checked, give epinephrine immediately 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, crampy pain

Action

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

Action

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.

_____ _____ _____ _____
Parent/Guardian Signature Date Physician/Healthcare Provider Signature Date

Physician Stamp

Contacts

Call 911
Parent/Guardian: _____
Doctor: _____
Phone: (___)____-_____
Phone: (___)____-_____

MAHOPAC CENTRAL SCHOOL DISTRICT

REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. **A provider order and parent/guardian permission is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes.** These medications should be identified by checking the appropriate boxes below.

Student Name: _____ DOB_____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

____ Allergy and requires Epinephrine Auto-injector

____ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication

____ Diabetes and requires Insulin/Glucagon/Diabetes Supplies

_____which requires rapid administration of_____

(State Diagnosis) (Medication Name)

Signature: _____ Date: _____

Health Care Provider

Health Care Provider Stamp

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and my carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: _____ Date: _____

Please return to the School Nurse.

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