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 Doctor:_____ Phone: (___)_____-_____
Parent/Guardian:_____ Phone: (___)_____-_____

MAHOPAC CENTRAL SCHOOL DISTRICT

178 East Lake Blvd., Mahopac, NY 10541-1666 (845) 628-3415 Fax (845) 628-0261

SELF-MEDICATION RELEASE FORM

This form may be used for **Epi-Pen** for students with severe allergies to foods, bee stings or other substances.

Date _____

Student Name _____ Grade _____

has been instructed in the proper use of the following medication procedures:

_____

_____

Although an **Epi-Pen** may pose a danger to other students, it is my medical opinion that this child is sufficiently mature and responsible to carry such a device.

We _____ / _____
Physician Signature *Phone*

and _____ / _____
Parent/Guardian Signature *Phone*

request that _____
Student Name

be permitted to carry an **Epi-Pen** on his/her person or leave it with his teacher while in class, as we consider him/her responsible. He/she has been instructed in and understands the purpose of the medication and the appropriate method and frequency of use of this medication. If it is necessary for him/her to use the medication, he/she will go to the School Nurse immediately for evaluation and consultation regarding the need for any further medical care.

NOTE: If a student and parent request that the student carry his/her own medication this form must be completed **in addition** to the routine district medication form. New medication forms and self medication forms must be completed each school year.