NYACK PUBLIC SCHOOLS

FORM REQUIRES MD SIGNATURE

Allergy Action Plan - *Requires MD signature*

Student: _____ D.O.B: _____ Gr:_____

ALLERGY TO: _____

Asthmatic: ☐ Yes* ☐ No *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION - Systems: Symptoms:

•**MOUTH** itching & swelling of the lips, tongue, or mouth
•**THROAT*** itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
•**SKIN** hives, itchy rash, and/or swelling about the face or extremities
•**GUT** nausea, abdominal cramps, vomiting, and/or diarrhea
•**LUNG*** shortness of breath, repetitive coughing, and/or wheezing
•**HEART*** "thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life threatening situation.

ACTION FOR MINOR REACTION

1. If the **only symptom(s)** are: MILD - hives, itchy rash or itchy eyes
2. Give Benadryl: 25mg PO, may repeat in 1 hour if symptoms have not resolved
   medication/dose/route

Notify:
Parent/Guardian: _____
If condition worsens, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION

1. **If ingestion is suspected and/or symptom(s) are:** Moderate to Severe - Multi-system or respiratory involvement
2. IMMEDIATELY administer **EPIPEN: 0.15mg /0.3mg Epinephrine IM to outer thigh**
   medication/ CIRCLE ONE DOSE/route

   ☐→ Student may self carry EPIPEN and self administer medication as per MD orders
   (High School & Middle School ONLY. Elementary students may not self carry).

***MD Signature: _____ Date: _____ STAMP:**

Then call:
1. 911 (ask for advanced life support and EPIPEN)

2. Parent/Guardian: _____
3. Dr. _____ at _____

DO NOT HESITATE TO CALL 911!

School RN signature: _____ Date: _____