

QUINCY PUBLIC SCHOOL DISTRICT 172

ALLERGY ACTION PLAN

Place
Student
Picture
Here

PART I TO BE COMPLETED BY PARENT

Student _____ ID # _____ D.O.B. _____ School _____

ALLERGY TO _____ Teacher/Grade _____

Emergency Contacts:

Name/Relationship

Phone Number(s)

1). _____

1). _____ 2). _____

2). _____

1). _____ 2). _____

Asthmatic

☐ Yes*

☐ No

*Higher risk for Severe Reaction

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:



Lung

Shortness of
Breath, wheezing
repetitive cough



Heart

Pale or bluish
skin, faintness,
weak pulse, dizziness



Throat

Tight or hoarse
throat, trouble
breathing or
swallowing



Mouth

Significant
swelling of the
tongue or lips



Skin

Many hives over
Body, widespread
redness



Gut

Repetitive
vomiting, severe
diarrhea



Other

Feeling
something bad is
about to happen,
anxiety, confusion

Or a Combination

of symptoms
from different
body areas

1. INJECT EPINEPHRINE IMMEDIATELY.
2. Call 911. Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
 - Antihistamine
 - Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



Nose

Itchy or
Runny nose
Sneezing



Mouth

Itchy Mouth



Skin

A few hives
mild itch



Gut

Mild
nausea or
discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine—Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Student May Self Carry ☐ Yes ☐ No

Antihistamine—Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g. inhaler-bronchodilator if wheezing):

Licensed Health Care Provider
(Print)

Licensed Health Care Provider
(Signature)

Telephone

Date

Parent/Guardian Signature

Date

History and Current Status

- How many times has student had a reaction? ☐ Never ☐ Once, Age ____ ☐ More than once, explain: _____
- Explain their past reaction: _____
- Symptoms: _____
- What are the **early** signs and symptoms of your student's allergic reaction? (Be specific; include things the student might say) _____

Treatment

- Has your student previously used treatment or medication for their allergy? ☐ No ☐ Yes, Age ____
Treatment/medication used _____
- How effective was the student's response to previous treatment? _____
- Was there an emergency room visit? ☐ No ☐ Yes, explain _____
- Was the student admitted to the hospital? ☐ No ☐ Yes, explain _____
- Please describe any side effects or problems your child had in using the suggested treatment: _____

Self Care

- Is your student able to monitor and prevent their own exposures? ☐ No ☐ Yes
- Does your student:
 - Know what foods to avoid ☐ No ☐ Yes
 - Ask about food ingredients ☐ No ☐ Yes
 - Read and understand food labels ☐ No ☐ Yes
 - Tell an adult immediately after an exposure ☐ No ☐ Yes
 - Wear a medical alert bracelet, necklace, watchband ☐ No ☐ Yes
 - Tell peers and adults about the allergy ☐ No ☐ Yes
 - Firmly refuses a problem food ☐ No ☐ Yes
- Does your child know how to use emergency medication? ☐ No ☐ Yes
- Has your child ever administered their own emergency medication? ☐ No ☐ Yes

Explain any of the above: _____

Parental Permission for Student to Self-Carry Epinephrine ☐ No ☐ Yes

If yes, I hereby acknowledge that I am the parent and/or legal guardian of the above referenced student and that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, I hereby authorize the School District to allow my child to self-administer his or her lawfully prescribed Asthma Inhaler/Epinephrine medication during the following: (1) while in school; (2) while at a school-sponsored activity; (3) while under the supervision of school personnel; and (4) before or after normal school activities.

I further acknowledge and agree that the School District and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from my child's self-administration of asthma medication. I further acknowledge and agree that, in absence of willful and wanton conduct on the part of the School District and its employees and agents, I waive any claims that I might have against said parties arising out of my child's self-administration of said medication. In addition, I agree to indemnify and hold harmless the School District and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parties, from and against any and all claims, damages, causes of action or injuries incurred or resulting from my child's self-administration of said medication.

Parent/Guardian Signature

Date

QUINCY PUBLIC SCHOOL DISTRICT 172

ALLERGY ACTION PLAN

TO BE COMPLETED BY SCHOOL NURSE

Student _____ **ALLERGY** _____

ACTION PLAN CHECKLIST FOR SCHOOL PERSONNEL

- | | | | | | | | |
|--|--|--------------------------|--------------------------|--------------------------|-----------|--------------------------|------------|
| <input type="checkbox"/> Allergy Action Plan Part I and II, complete | <input type="checkbox"/> | yes | <input type="checkbox"/> | no | | | |
| <input type="checkbox"/> Antihistamine medication authorization complete | <input type="checkbox"/> | yes | <input type="checkbox"/> | no | | | |
| <input type="checkbox"/> Epinephrine medication authorization complete | <input type="checkbox"/> | yes | <input type="checkbox"/> | no | | | |
| <input type="checkbox"/> Medication self carried | <input type="checkbox"/> | yes | <input type="checkbox"/> | no | | | |
|
 | | | | | | | |
| <input type="checkbox"/> Medication stored: | _____ , _____
<div style="text-align: center;">(Location) (Location)</div> | | | | | | |
| <input type="checkbox"/> Expiration date of medication (s): | _____ , _____
<div style="text-align: center;">(Epinephrine) (Antihistamine)</div> | | | | | | |
|
 | | | | | | | |
| <input type="checkbox"/> Copies of plan provided to: | Educational | <input type="checkbox"/> | yes | <input type="checkbox"/> | no | <input type="checkbox"/> | n/a |
| | Athletic | <input type="checkbox"/> | yes | <input type="checkbox"/> | no | <input type="checkbox"/> | n/a |
| <input type="checkbox"/> Notify of specific allergy: Food Service | | <input type="checkbox"/> | yes | <input type="checkbox"/> | no | <input type="checkbox"/> | n/a |
| <input type="checkbox"/> Staff trained in medication Administration | | <input type="checkbox"/> | yes | <input type="checkbox"/> | no | | |

TRAINED STAFF IN ADDITION TO SCHOOL NURSE

Name	Date	Location
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Name	Date	Location
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The EpiPen is self-injecting. It is used in cases of anaphylaxis of any cause.



Directions for use:

- Remove gray safety cap and grasp EpiPen with your fist
- Press the black end of EpiPen against outer thigh until you hear a click and needle is released. EpiPen is designed to be used through clothing if necessary.
- **Maintain EpiPen in position for 10 seconds.**
- Remove EpiPen, call 911 for immediate medical attention
- Carefully place the used auto-injector (without bending the needle), needle-end first, into the storage tube of the carrying case that provides built-in needle protection after use. Then screw the cap of the stored tube back on completely, and give to the emergency responder to dispose of in the emergency room.

Full Allergy Action plan has been implemented.

Date _____

Adapted from: Virginia Department of Health, Virginia Department of Education (2004) *Guidelines for Specialized Health Care Procedures*
and from the Office of Catholic Schools Diocese of Arlington