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** _____

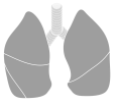
Emergency Contacts:

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:



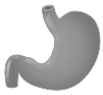
Lung
Shortness of Breath, wheezing repetitive cough

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

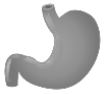
1. INJECT EPINEPHRINE IMMEDIATELY.
2. Call 911. Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
   - Consider giving additional medications following epinephrine:
     - Antihistamine
     - Inhaler (bronchodilator) if wheezing
   - 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**

PART III **TO BE COMPLETED BY PARENT**

History and Current Status

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

Treatment

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

Self Care

1.	Is your student able to monitor and prevent their own exposures?	☐ No ☐ Yes
2.	Does your student:	
	a. Know what foods to avoid	☐ No ☐ Yes
	b. Ask about food ingredients	☐ No ☐ Yes
	c. Read and understand food labels	☐ No ☐ Yes
	d. Tell an adult immediately after an exposure	☐ No ☐ Yes
	e. Wear a medical alert bracelet, necklace, watchband	☐ No ☐ Yes
	f. Tell peers and adults about the allergy	☐ No ☐ Yes
	g. Firmly refuses a problem food	☐ No ☐ Yes
3.	Does your child know how to use emergency medication?	☐ No ☐ Yes
4.	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

PART III	**TO BE COMPLETED BY SCHOOL NURSE**

Student _____ ALLERGY _____

ACTION PLAN CHECKLIST FOR SCHOOL PERSONNEL

- Allergy Action Plan Part I and II, complete □ **yes** □ **no**
- Antihistamine medication authorization complete □ **yes** □ **no**
- Epinephrine medication authorization complete □ **yes** □ **no**
- Medication self carried □ **yes** □ **no**

- Medication stored:_____(Location),_____(Location)
- Expiration date of medication (s):_____(Epinephrine),_____(Antihistamine)

- Copies of plan provided to: Educational □ **yes** □ **no** □ **n/a**
  Athletic □ **yes** □ **no** □ **n/a**
- Notify of specific allergy: Food Service □ **yes** □ **no** □ **n/a**
- Staff trained in medication Administration □ **yes** □ **no**

PART IV	**TRAINED STAFF IN ADDITION TO SCHOOL NURSE**

Name_____ Date_____ Location_____

Name_____ Date_____ Location_____

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.

_____ _____

School Nurse **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