**Allergy Action Plan**

**BCPS Emergency Health Care Plan**

**Name: ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.:\_\_ /\_\_ /\_\_\_\_\_**

**Allergy to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_** lbs.

. Child has had **asthma:** Yes (higher risk for a severe reaction) No

Child has had anaphylaxis: Yes No

**If an allergic reaction has occurred the following Action is needed:**

**Medications/ Doses:**

Epinephrine prn **severe** allergic response via IM: ***circle one:***

*0.3mg Auto-injectable Epinephrine 0.15mg Auto-injectable Epinephrine*

Antihistamine prn **mild** allergic response: Diphenhydramine ***(circle one)*** liquid / pill x \_\_\_\_\_mg po

Other (i.e.: inhaler-bronchodilator) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any SEVERE SYMPTOMS after suspected or known**

**ingestion: 1. INJECT EPINEPHRINE**

**IMMEDIATELY**

**One or more** of the following:

2. Call 911

LUNG: Short of breath, wheeze, repetitive cough

HEART: Pale, blue, faint, weak pulse, dizzy, 3. Begin monitoring (see box

confused at bottom of page)

THROAT: Tight, hoarse, trouble breathing/swallowing

MOUTH: Obstructive swelling (tongue and/or lips) 4. Give additional medication

SKIN: Many hives over body -Antihistamine

-Inhaler (bronchodilator)

Or **combination** of symptoms from different body areas: if asthma

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)

GUT: Vomiting, diarrhea, crampy pain

**MILD SYMPTOMS ONLY: 1. GIVE ANTIHISTAMINE**

2. Stay with student; alert

MOUTH: Itchy mouth nurse and parent

SKIN: A few hives around mouth/face, mild itch 3. If symptoms progress (see

GUT: Mild nausea/discomfort above), USE EPINEPHRINE

4. Begin monitoring

**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.

Possible side effects of Epinephrine administration include but are not limited to:

* Upset stomach, dizziness, sweating, nervousness, apprehension, pale skin, headache, anxiety, tremors or shakiness, rapid heart rate, stronger or irregular heartbeat

Possible side effects of Diphenhydramine administration include but are not limited to:

* Tiredness, sleepiness, dry mouth (not allowed to drive after administration)

*Self-Administration is determined by the physician and applies to Inhaler or Auto-Injectable Epinephrine for any student*.

The following student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has knowledge of this medication and has demonstrated the capability of self-administering this medicine. **Physician Must Circle Below**

**Inhaler Auto-Inject Epinephrine**

This child needs supervision and therefore **may not** carry:

**Inhaler**  **Auto- Inject Epinephrine**

Mother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TP#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TP#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TP#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TP#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do Not Hesitate to Administer Medication or Call Rescue Squad**

**Even If Parent or Doctor Cannot Be Reached**

I give permission for trained school personnel to follow this medical plan, administer auto-injectable epinephrine, diphenhydramine, and other emergency care for my child, and contact the physician if necessary. I assume full responsibility for providing the school with the medication and supplies

needed, and providing medical updates as indicated. I also consent to the release of the information contained in this plan to any staff members that may need to know this information to maintain my

child’s health and safely. I understand that this care plan is valid for the current school year only.

I give permission to fax this form to my child’s medical office and school clinic and for school staff

to speak with my child’s doctor regarding this care plan or my child’s condition.

**Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician/Healthcare Provider Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_**