



Allergy Action Plan

Student's Name: _____ Date of Birth: _____ School: _____

Medication Information:

Allergy to: _____

Student has Asthma: ☐ Yes, ☐ No

Student has had Anaphylaxis: ☐ Yes, ☐ No

Medications:	Route:	Dose:

For SEVERE Allergy and ANAPHYLAXIS

What to look for

If ANY of these symptoms after exposure:

- LUNG: shortness of breath, wheezing, repetitive coughing
- HEART: pale or bluish skin, weak pulse, dizziness
- THROAT: tight or hoarse, 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 of "doom," anxiety, confusion

Give epinephrine now!

What to do

1. Stay calm! Inject epinephrine right away!
2. Call 911.
3. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine
4. Stay with student and:
 - Keep student still and calm
 - Call parents
 - Give second dose of epinephrine if symptoms get worse, continue, or do not get better in 5 minutes

For MILD Allergic Reaction

What to look for

If mild symptoms such as:

- Itchy or runny nose, sneezing
- Itchy mouth
- A few hives
- Mild stomach ache, nausea, or discomfort

Monitor Child

What to do

1. Stay calm and watch student closely
2. Give antihistamine (if prescribed)
3. Call parents
4. If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, give epinephrine.

TO BE COMPLETED BY MEDICAL PROVIDER:

Practitioner Printed Name: _____ Phone: _____

Clinic/Health care system: _____ Fax: _____

Practitioner Signature: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I give consent for school personnel to administer medication as described above. I authorize communication between the prescribing health care provider, the school nurse, and trained school personnel necessary for the management and administration of this medication. I have read the procedures outlined in board policy 5330 and assume responsibilities as required.

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY SCHOOL STAFF:

Verify all when medication is delivered to school:

- ☐ All above information is completed, including signatures
- ☐ Medication is in original packaging with clear dosing instructions/prescription label.
- ☐ Written instructions above match written instructions on medical packaging.

Staff signature: _____ Date: _____