

**New Albany-Floyd County Consolidated School Corporation School Health Services
2017-2018 School Year
Allergy Action Plan**

To be completed by prescribing Health Care Provider

Student Name: _____ Date of Birth: _____ School: _____ Grade: ____ Teacher: _____

DESCRIPTION OF ALLERGY:

Allergy to: _____

Has student had reaction before: Yes No

If yes, describe reaction: _____

For food allergies:

Is student likely to have a reaction from:








inhaling contacting ingesting the named allergen?

Is student required to sit at a special table in the cafeteria and have a classroom that is designated free of the named allergen? Yes No

List allergens to avoid at table/classroom? _____

Wt: _____ lbs **Asthma:** Yes (higher risk of severe reaction) No

SEVERE SYMPTOMS

 LUNG Short of breath, wheezing, repetitive cough	 HEART Pale, blue, faint, weak pulse, dizzy	 THROAT Tight, hoarse, trouble breathing/swallowing	 MOUTH Significant swelling of the tongue and/or lips
 SKIN Many hives over body, widespread redness	 GUT Repetitive vomiting or severe diarrhea	 OTHER Feeling something bad is about to happen, anxiety, confusion	OR A COMBINATION of mild or severe symptoms from different body areas.

Is emergency epinephrine needed at school for the student? Yes No

If yes, please specify:

Medication Brand: _____ **DOSE:** 0.15 mg (< than 55-66 lbs) –OR–

0.3 mg (> 55-66 lbs) PER INJECTION TO OUTER THIGH TO BE ADMINISTERED:

As soon as exposed to allergen, even if no symptoms present

At onset of ANY symptoms (see lists) if allergen was likely eaten/encountered

At onset of severe symptoms (see list) or combination of mild or severe symptoms from different body areas

A second time if available if symptoms continue or return in 5 or more minutes

Other: _____

Does student have other medication for DURING allergic reaction? Yes No





If student has **OTHER EMERGENCY MEDICATION** for reaction, please specify:

Name _____

Dosage _____

Time/Symptoms requiring med _____

MILD SYMPTOMS

 NOSE Itchy/runny nose, sneezing	 MOUTH Itchy mouth
 SKIN A few hives, mild itch	 GUT Mild nausea/discomfort

THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR

Student Name: _____

Date of Birth: _____

In the event of a reaction:

1. Inject Epinephrine immediately according to plan.
2. Call 911 and school nurse. **Request ambulance with epinephrine.**
3. Notify school personnel trained in CPR/First Aid to respond and initiate CPR if needed prior to EMS arrival.
4. If additional medications prescribed to give during a reaction, give them according to plan.
5. Consider lying on the back with legs elevated, but alternative positioning is needed for vomiting (side lying, head to side) or difficulty breathing (sitting). Do **NOT** have student rise to upright position once lying.
6. Notify parent/guardian.
7. If symptoms do not improve, or symptoms return, give additional dose of epinephrine if plan says to do so.
8. NAFCS staff must accompany student on ambulance unless parent and/or emergency contact accompanies them.
9. Document event and any medications given. Give used device to EMS.
10. Ensure assistive personnel notifies ASC of 911 call made.
11. If prescribed medical treatment is not available to school personnel, call EMS for any severe symptoms or combination of mild or severe symptoms from different body areas. Contact school nurse.
12. Other: _____

Prescribing Health Care Provider:

Prescriber authorization for possession and/or self-administration of medication.
The student has been instructed in how to self-administer this medication. Yes No

The Allergy Action Plan and medication orders have been developed and approved by:

Prescriber Printed Name Phone Fax

Prescriber Signature Date

Parent/Guardian:

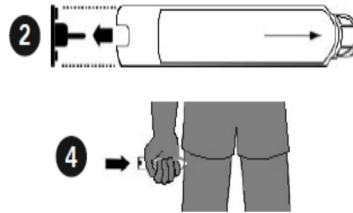
I give permission to the school nurse and other trained personnel members to perform the tasks as outlined in the Allergy Action Plan. I understand that a school nurse is not always present at my child's school and I give consent for other trained school personnel to provide care to my child as needed according to this plan. I give permission for the school nurse and prescribing health care provider to exchange information regarding any necessary medication order clarifications, response to medication, and adverse effects. I also consent to the release of information contained in this Allergy Action Plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. Unless other arrangements are made, I give the school permission to send home medication that has been in its possession with my child at the end of the school year.

Parent/Guardian authorization for possession and/or self-administration of medication.

Student's Parent/Guardian Signature Date

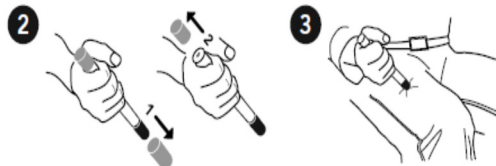
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



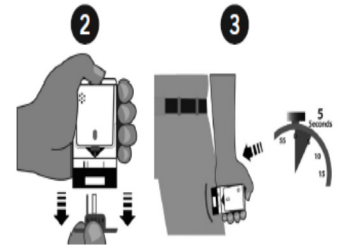
ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



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