

ALLERGY ACTION PLAN

Dear Parent/Guardian,

If your child has a life-threatening allergy requiring emergency medication to be kept at school, (i.e.: Epinephrine, Auvi-Q, and/or Benadryl), please forward the following items to the school:

- A completed Emergency Allergy Action Plan (attached) signed by both you and your child's physician with instructions the school is to follow in the event of an allergic reaction in school.
- Medication is to be dropped off by the parent/guardian. Medication is to be in the original container with the label provided by the pharmacist.
- Students are permitted to carry their own emergency medication if authorized by their physician, parent/guardian, and the school. *Children who carry their own emergency medication **MUST** have the appropriate documents on file in the school clinic **AND** back up EpiPen/Auvi-Q on file in the clinic. For those students who are not permitted to carry the medication, it will be located in the clinic and readily available should the need occur.
- When completing the allergy action plan for incoming kindergarten students, please do not complete the plan prior to the end of the current school year.
- A medication administration form does not need to be completed with the allergy action plan.

If your child's allergy is **NOT** life-threatening and does **NOT** require emergency medication a physician's note declaring the allergy is **NOT** life threatening and what to do in the event of exposure will be acceptable.

If you have any questions, please contact me at 440-356-6720.

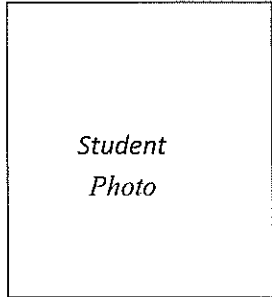
Sincerely,

Jenni Rusin, RN
Rocky River City School District
440-356-6720

ALLERGY ACTION PLAN

USE 1 FORM PER CHILD FOR EACH ALLERGEN

Student _____ School _____
 DOB _____ Age _____ Weight _____ Grade/Rm _____
 Allergy to _____



START DATE: _____ END DATE: _____

- Student has asthma. Yes No (If yes, higher chance of severe reaction)
 Student has had anaphylaxis. Yes No
 Student may carry epinephrine. Yes No (if yes, complete next page)
 Student may give him/herself medicine. Yes No (If student refuses/is unable to self-treat, an adult must give medicine.)

IMPORTANT REMINDER

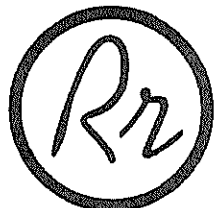
Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

<p>For Severe Allergy and Anaphylaxis</p> <p>What to look for </p> <p>If child has ANY of these severe symptoms after eating the food or having a sting, give epinephrine.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Skin color is pale or has a bluish color <input type="checkbox"/> Weak pulse <input type="checkbox"/> Fainting or dizziness <input type="checkbox"/> Tight or hoarse throat <input type="checkbox"/> Trouble breathing or swallowing <input type="checkbox"/> Swelling of lips or tongue that bother breathing <input type="checkbox"/> Vomiting or diarrhea (if severe or combined with other symptoms) <input type="checkbox"/> Many hives or redness over body <input type="checkbox"/> Feeling of "doom," confusion, altered consciousness, or agitation <p><input type="checkbox"/> SPECIAL SITUATION: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____ Even if child has MILD symptoms after a sting or eating these foods, give epinephrine.</p>	<p>Give epinephrine!</p> <p>What to do</p> <ol style="list-style-type: none"> 1. Inject epinephrine right away! Note time when epinephrine was given. 2. Call 911. <ul style="list-style-type: none"> <input type="checkbox"/> Ask for ambulance with epinephrine. <input type="checkbox"/> Tell rescue squad when epinephrine was given. 3. Stay with child and: <ul style="list-style-type: none"> <input type="checkbox"/> Call parents and child's doctor. <input type="checkbox"/> Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes. <input type="checkbox"/> Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side. 4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine. <ul style="list-style-type: none"> <input type="checkbox"/> Antihistamine <input type="checkbox"/> Inhaler/bronchodilator
<p>For Mild Allergic Reaction</p> <p>What to look for </p> <p>If child has had any mild symptoms, monitor child.</p> <p>Symptoms may include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Itchy nose, sneezing, itchy mouth <input type="checkbox"/> A few hives <input type="checkbox"/> Mild stomach nausea or discomfort 	<p>Monitor child</p> <p>What to do</p> <p>Stay with child and:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Watch child closely. <input type="checkbox"/> Give antihistamine (if prescribed). <input type="checkbox"/> Call parents and child's doctor. <input type="checkbox"/> If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis")

Medication/Doses

Epinephrine autoinjector, intramuscular (list type): _____ Dose: 0.15 mg 0.30 mg
 Antihistamine, by mouth (type and dose): _____
 Other (for example, inhaler/bronchodilator if student has asthma): _____

<p>Parent/Guardian Authorization Signature _____ Date _____</p> <p>Emergency Contacts/Relationship</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<p>Physician/HCP Authorization Signature _____ Date _____</p> <p>Telephone number _____</p>
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***** (To be completed ONLY if student will be carrying an Epinephrine Autoinjector) *****

AUTHORIZATION FOR STUDENT POSSESSION AND USE OF AN EPINEPHRINE AUTOINJECTOR
(In accordance with ORC 3313.718/8313.141)

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

Parent /Guardian signature	Date
Parent /Guardian name	Parent /Guardian emergency telephone number ()

This section must be completed and signed by the medication prescriber.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)
Circumstances for use of the epinephrine autoinjector	
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief	

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the prescriber)
To a student for which it is not prescribed who receives a dose

Special instructions

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ()

Developed in collaboration with the Ohio Association of School Nurses.
 HEA 4222 3/07

