New Albany-Floyd County Consolidated School Corporation School Health Services
2014-2015 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: _____

For food allergies:
Is student likely to have a reaction from:
☐ inhaling ☐contacting ☐ingesting the named allergen?
Does student require a table in cafeteria that is free of the named allergen? ____
Are any special classroom restrictions necessary? _____
Are any food substitutions necessary? _____

Has student had reaction before: ☐ Yes ☐ No
If yes, describe reaction: _____

_____

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

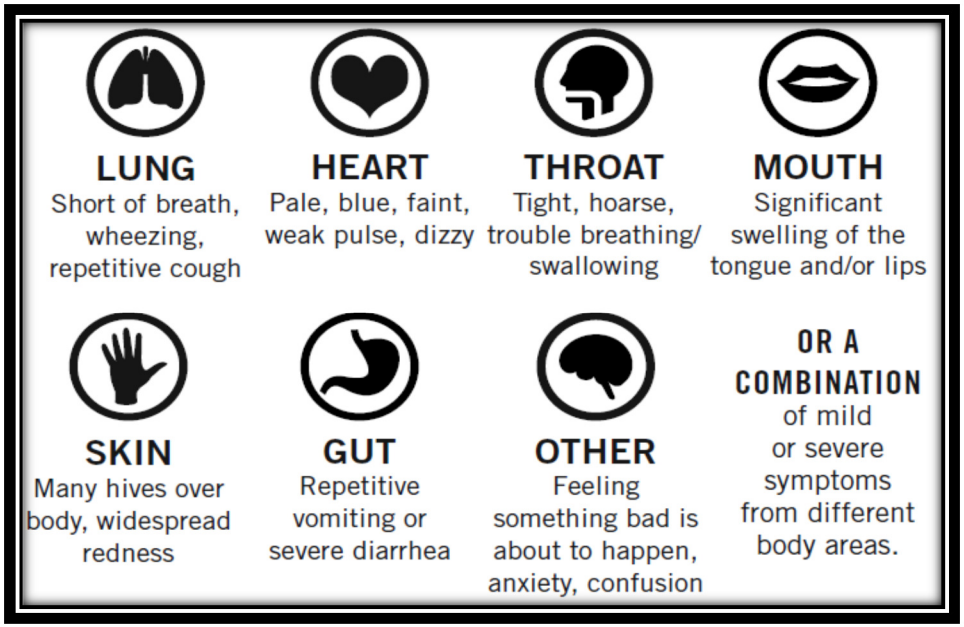
Is emergency epinephrine needed at school for the student? ☐ Yes ☐ No

If yes, please specify:
Medication Brand: _____
DOSE: _____ MG 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 5-20 minutes
☐ Other: _____

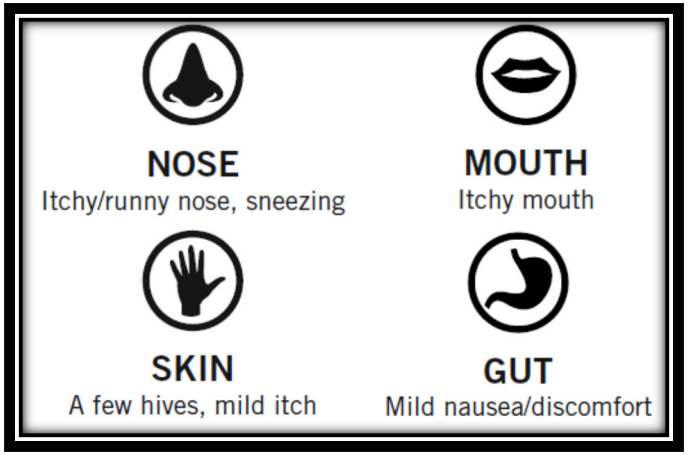
Does the student have other medication for allergic reaction? ☐ Yes ☐ No

If student has **OTHER MEDICATION**, please specify:
Name _____
Dosage _____
Time/Symptoms requiring med _____

SEVERE SYMPTOMS



MILD SYMPTOMS



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

Student Name: _____

Date of Birth: _____

<u>In the event of a reaction</u>:

1. Inject Epinephrine immediately according to plan.
2. Call EMS (9-911). **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. Lay student flat and raise legs. If breathing is difficult or they are vomiting, let them lie on side.
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.
10. 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.
11. 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:

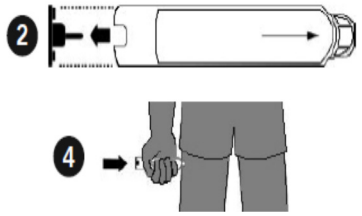
I give permission to the school nurse and other trained personnel members to perform the tasks as outlined in the Allergy Action Plan. I understand that a school nurse is not always present at my child's school and I give consent for other trained school personnel to provide care to my child as needed 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

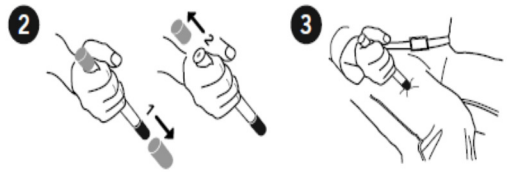
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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.



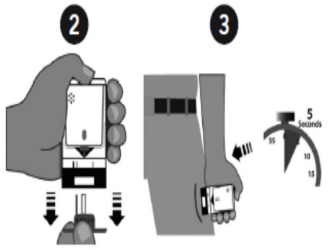
ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

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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