Immaculate Conception School

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Allergy Action Plan

Action Plan Period – From ____August_____ To _____June_____

Student's Name: _____ Date of Birth: _____

ALLERGY TO: _____ Grade/Class: _____

Is student asthmatic? Yes ☐ No ☐

Signs/Symptoms of an Allergic Reaction

- Mouth – Itching, tingling, or swelling of lips, tongue, mouth
- Skin – Hives, itchy rash, swelling of the face or extremities
- GI – Nausea, abdominal cramps, vomiting, diarrhea
- Throat – Tightening of throat, hoarseness, hacking cough
- Lungs—Shortness of breath, repetitive coughing, wheezing
- Heart – Weak or thready pulse, fainting, pale, blueness

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening reaction.

ACTION FOR MINOR REACTION

1. If only symptom(s) are: _____, give _____
   name of oral medication and dose
2. Then call:
   Parent(s) _____ Phone Number(s) _____

   Doctor _____ at _____

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION

1. If ingestion is suspect and/or symptoms are: _____
give: **Epinephrine:** Inject (circle one) EpiPen EpiPen Jr. Twinject 0.3 mg Twinject 0.15 mg

Other: Give _____
name of oral medication and dose

Then make the following emergency calls

2. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

3. Dr. _____ Phone Number _____

4. Parent _____ Phone Number(s) _____

Other Emergency Contacts:

Name/Relationship	Phone Numbers	
_____	_____	_____
_____	_____	_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE THE STUDENT TO MEDICAL FACILITY

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

Parent Consent for Management of Allergic Reaction at School

I, the parent or guardian of _____, request that this school Food Allergy Action Plan be used to guide the care of my child. I agree to:

1. **Provide necessary supplies, equipment and medications**
2. **Notify the school of any changes in the student's health status**
3. **Notify the school and complete new consent for changes in orders from the student's health care provider**
4. **Authorize the school nurse to communicate with the primary care provider/specialist as needed**
5. **Allow school staff interacting directly with my child to be informed about his/her special needs while at school.**

_____	_____	_____
(Parent Name)	(Parent Signature)	(Date)