Wayne County Schools Career Center

518 West Prospect Street-Smithville-Ohio-44667-Phone-330-669-7011-Fax-330-669-7001

STUDENT ALLERGY/ANAPHYLACTIC ACTION PLAN

The student listed below has been diagnosed with an allergy to food, medication, or insects. This form will assist in the management of his/her allergy and should be kept in the students medical file and taken on all field trips along with the students medication

STUDENT NAME:_____D.O.B.:_____GRADE:_____ASTHMA: YES_____NO_____

STREET:_____CITY:_____ZIP:_____

INSECT STING:_____ FOOD ALLERGY:_____ OTHER:_____

TREATING PHYSICIAN:_____PHONE:_____

DATE AND SYMPTOMS OF LAST REACTION:_____

LOCATION OF MEDICATION:__STUDENT __BACKPACK __ CLINIC___OFFICE

PRIMARY CONTACT	**SECONDARY CONTACT**
PARENT/GUARDIAN NAME:	NAME:_____
_____	RELATION:_____
PHONE #: CELL:_____	PHONE#: CELL:_____
HOME:_____	HOME: -_____
WORK:_____	WORK:_____

SIGNS OF AN ALLERGIC REACTION

SYMPTOMS:	**GIVE CHECKED MEDICATION:**	
SYMPTOMS BELOW CAN PROGRESS QUICKLY AND CAN POTENTIALLY BE LIFE-THREATENING		
• If contact with allergen but no symptoms:	____Epinephrine	_____Antihistamine
• Nose/Eyes: Itching, sneezing, congestion, runny nose, red eyes, tearing	____Epinephrine	_____Antihistamine
• Mouth: Itching, tingling, or swelling of lips, tongue, mouth	____Epinephrine	_____Antihistamine
• Skin: Hives, itchy rash, swelling of the face or extremities	____Epinephrine	_____Antihistamine
• Gut: Nausea, abdominal cramps, vomiting, diarrhea	____Epinephrine	_____Antihistamine
• Throat: Tightening of throat, hoarseness, hacking cough, Difficulty swallowing or speaking, itchiness in ear canals	____Epinephrine	_____Antihistamine
• Lung: Shortness of breath, repetitive coughing, wheezing, chest tightness	____Epinephrine	_____Antihistamine

• Heart: Thready pulse, low blood pressure, fainting, pale, blue	____Epinephrine	_____Antihistamine
• Other: _____	____Epinephrine	_____Antihistamine
• If reaction is progressing (several of the above areas affected) give:	____Epinephrine	_____Antihistamine

MEDICATION AND DOSAGE

Epinephrine: (Circle one) Epipen 0.3mg EpiPen Jr. 0.15mg Twinject 0.3mg Twinject 0.15mg Auvi-Q 0.15mg Auvi-Q 0.3mg

Other (please list) _____

A second EpiPen may be administered if no improvement in symptoms occur within approximately _____ min. ___yes ___no

Antihistamine: Medication Name:_____Dose:_____Route:_____

Other: Medication Name:_____Dose:_____Route:_____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

This student is capable of self-administration and may carry medication and self-administer in school ___yes ___no

Possible Side Effects:_____

Direct Contact shall be made to the parent/physician should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state_____

EMERGENCY CALLS

1. Call **911 IMMEDIATELY any time EPI is given. State that an allergic reaction has been treated and additional epinephrine may be needed.**
2. Call parent/guardian or other emergency contact to let them know student was administered EPI and is headed to the hospital.

EVEN IN PARENT/GUARDIAN CANNOT BEREACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY

AGREEMENT:

- I am requesting permission for my child named above to receive medication in accordance with this action plan. I will assume responsibility for safe delivery of the medication/drug to school. The medication but be brought to school in the container in which it was dispensed by the prescriber or licensed pharmacist.
- I will notify the school immediately if there is any change in the use of the medication or prescribed treatment. A revised action plan will need to be on file signed by the prescriber.
- I release and agree to hold the Board of Education, it's officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization

SIGNATURES: Represent agreement with the above information and action plan

PARENT/GUARDIAN:_____DATE:_____

LICENSED PRESCRIBER:_____DATE:_____

SCHOOL NURSE:_____DATE:_____