Sturgis Charter Public School

An International Baccalaureate Diploma School

ALLERGY ACTION PLAN

Student Photo

Student Name _____ **D.O.B.** _____
Advisor _____ **School Nurse** _____
Health Care Provider _____ **Phone** _____
History of Asthma ____ No ____ Yes-Higher risk for severe reaction

ALLERGY: (check appropriate) **To be completed by Health Care Provider**

- ☐ **Foods (list):**
- ☐ **Medications (list):**
- ☐ **Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)**
- ☐ **Stinging Insects (list):**

RECOGNITION AND TREATMENT

Chart to be completed by Health Care Provider ONLY		**Give CHECKED Medication**	
Symptoms of reaction include:		EpiPen	Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut+	Nausea, abdominal cramps, vomiting, diarrhea		
Throat+	Tightening of throat, hoarseness, hacking cough		
Lung+	Shortness of breath, repetitive coughing, wheezing		
Heart+	Thready pulse, low BP, fainting, pale, blueness		
Neuro+	Disorientation, dizziness, loss of conscience		
Other			
If reaction is progressing (several of the above areas affected), GIVE:			
The severity of symptoms can quickly change. +Potentially life-threatening			

DOSAGE:

Epinephrine: Inject into outer thigh ☐ **EpiPen 0.3 mg** OR ☐ **EpiPen Jr. 0.15 mg** (see reverse for instructions)
Antihistamine: Benadryl (or equivalent) _____mg To be given by mouth o*nly if able to swallow*.
Other: _____

Medical Releases: **Please check the appropriate boxes.**

	EpiPen	Antihistamine
Student may **carry and self-administer** medication	☐	☐ This child has received instruction regarding the need for and proper use of the EpiPen and Antihistamine and has been advised to inform a responsible adult if the EpiPen or Antihistamine is needed and/or self-administered.
Student may **carry but not self-administer** medication	☐	☐ This child has received instruction regarding the need for the EpiPen/Antihistamine and has been advised to inform a responsible adult if the EpiPen or Antihistamine is needed.
Student may **not carry or self-administer** medication	☐	☐ This child has received instruction in the importance of notifying a responsible adult if he/she comes into contact with an allergen or begins to develop signs and symptoms of an allergic reaction.

Please note: The medication instructions in this Allergy Action Plan will serve as physician's orders.

Health Care Provider Signature _____ Date _____

Section Two: To Be Completed by Parent/Guardian, Student and School

Student Name _____ D.O.B. _____

Parent/Guardian AUTHORIZATIONS:

□ **I want my child to carry and self-administer his/her EpiPen and Benadryl** and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of the EpiPen or Benadryl.

□ **I do not want my child to self-administer his/her EpiPen**. However, my child may carry his/her EpiPen and self-administer his/her Benadryl if deemed appropriate by his/her health care provider and the school nurse.

□ **I do not want my child to self-administer any of his/her medications** but for the safety of my child he/she may carry his/her EpiPen and Benadryl and notify a school faculty member immediately if there has been contact or suspected contact with an allergen or he/she is showing symptoms of an allergic reaction.

□ **Backup medication** should be stored in the health office in case a student forgets or loses his/her EpiPen and/or Benadryl. I understand that if backup medication is not provided to the health office for my child the school district is not responsible if my child is without emergency medication when it is needed.

Your signature gives permission for the nurse to contact and receive additional information from your child's health care provider regarding the allergic condition(s) and the prescribed medication.

Parent/Guardian Signature: _____ Date:_____

Student Agreement:

□ I have been trained in the use of my EpiPen and allergy medication and understand the signs and symptoms for which they are given;

□ I agree to carry my EpiPen and/or Benadryl with me at all times;

□ I will notify a responsible adult **IMMEDIATELY** when EpiPen is needed and/or administered;

□ I will not share my medication with other students or leave my EpiPen unattended;

□ I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature: _____ Date _____

Approved by Nurse/Principal Signature: _____ Date _____

□ Back-up medication is stored at school □ Yes □ No

EMERGENCY CONTACTS

	Name/Relationship	Home	Work	Cell
Parent/Guardian				
Parent/Guardian				
Other:				
Other:				

Staff Members Trained

Name	Location/Room	Trained By

This form is adapted from The Food Allergy Anaphylaxis Network, "Food Allergy Action Plan" by the Alaska Asthma Coalition.