ST. JOHN'S Lutheran School

Allergy Action Plan

Student Picture

To be completed by Parent/Guardian and Physician

Student's Name: _____ **D.O.B.:** _____

ALLERGY TO:_____

Asthmatic: Yes*_____ No _____ *higher risk for severe reaction **Teacher:** _____

Symptoms	**Circle** medication to be given (All medication Must be authorized by a physician.)	
If food allergen has been ingested, but no symptoms.	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, itching, tingling	Epinephrine	Antihistamine
Lung** Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
Heart** Weak or thread pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
Other** _____	Epinephrine	Antihistamine
If reaction is progressing (several of the above areas are affected)	Epinephrine	Antihistamine

**** Potentially life-threatening. The severity of symptoms can quickly change.**

DOSAGE

Epinephrine: inject intramuscularly (circle one) **EpiPen** **EpiPen Jr.** **Twinject 0.3 mg** **Twinject 0.15 mg**

Antihistamine: give_____
Medication/dose/route

Other: give_____
Medication/dose/route

___This student has been instructed in the proper way to use his/her Epi Pen. It is my opinion that this Student is responsible and should be allowed to carry and self-administer his/her EpiPen.

____ It is my opinion that this student should not carry his/her Epi Pen at school. The Epi Pen will be kept in the health clinic and administered by designated staff.

Student Name: _____**DOB:** _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR CALL 911.

This plan of care is in accordance with the student's medical management and is to be followed at school.

Physician Signature: _____ **Date:** _____

Parent/Guardian's Signature: _____**Date:** _____

EMERGENCY PLAN OF ACTION

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

Dr. _____ **Phone Number:** _____

Parent _____ **Phone Number(s)** _____

Parent _____ **Phone Number(s)** _____

Emergency Contact: _____ **Phone Number**_____

Student Information

What is your child allergic to: _____

_____

How many times has your child been seen in the emergency room for this condition in the last year?

_____

Please list symptoms your child has had during previous allergic reaction: _____

_____

Other comments/instructions: _____

_____

Outline a plan for classroom parties and/or food in classroom: _____

_____

Outline a plan for field trips: _____

_____

Outline a plan for when your child is in Extended Care: _____

_____

Will this student be carrying an Epi Pen in Extended Care? _____

Parent /Guardian Consent: I approve this health care and emergency action plan for my child. I authorize unlicensed trained personnel of St. John's Lutheran School to administer and/or assist my child with an **Epi Pen** (epinephrine) and/or other prescribed medication as outlined in this plan. I understand that I am responsible for supplying any medication, supplies and/or equipment, and dietary supplements needed by my child to manage his/her allergy/reaction. This health care plan can be updated at any time my child's circumstances require modifications in treatment, and will be updated at the beginning of each school year. I agree to notify the school if a change occurs in my child's health plan. I also consent to the release of the information contained in this care plan to St. John's Lutheran School personnel who care for my child and who may need to know this information to maintain my child's health and safety.

Parent/Guardian Signature _____Date _____