

## Allergy Action Plan/504



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_

Bus     Car     Walk

Location(s) where Epi-pen is/are stored:     Health room     Office     Backpack     Other

**TO BE COMPLETED BY LICENSED HEALTHCARE PROFESSIONAL**

**SEVERE ALLERGY TO:** \_\_\_\_\_

**Other allergies:** \_\_\_\_\_

History of past reactions: \_\_\_\_\_

Date of last reaction: \_\_\_\_\_

**Asthma**    \*Yes\*     \*\*High Risk for severe reaction    No

Student weight:    Less than 66 pounds  (Epi-pen, Jr)    More than 66 pounds  (Epi-pen)

**◆ SIGNS OF AN ALLERGIC REACTION ◆**

- **MOUTH**                    itching, tingling, or swelling of the lips, tongue or mouth
- **THROAT**                    sense of tightness, itching and/or tightness in the throat, hoarseness, change in voice, hacking cough
- **SKIN**                        hives, itchy rash, and/or swelling about the face or extremities
- **GUT**                         nausea, stomachache, abdominal cramps, vomiting, and/or diarrhea
- **LUNG**                        shortness of breath, repetitive coughing, and/or wheezing
- **HEART**                        weakness, passing out, "thread" pulse, blueness, pale
- **GENERAL**                    panic, sudden fatigue, chills, fear of impending doom

**◆ MEDICATION ORDERS ◆**

EpiPen (0.3mg) \_\_\_\_\_ EpiPen Jr (0.15mg) \_\_\_\_\_

Side Effects \_\_\_\_\_

Antihistamine \_\_\_\_\_ Dosage \_\_\_\_\_

Side Effects \_\_\_\_\_

Yes     No     Can this student responsibly carry and self-administer emergency medications?

**Licensed Health Care Professional authorizing administration of above medications:**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

**◆ ACTION PLAN ◆**

1. Administer medication as ordered above
2. Note time of reaction \_\_\_\_\_ Note time medication given \_\_\_\_\_
3. CALL 911 IMMEDIATELY report EpiPen has been given and what type of allergy
4. Notify nurse, family and school administrator
5. An adult must stay with the student at all times until EMS arrives
6. Give to EMS or dispose of used EpiPen in sharps container
7. Complete Incident Report

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**Individual Considerations**

**Bus –Transportation should be alerted to student’s allergy.**

- ◆ This student carries EpiPen® on the bus:  Yes  No
- ◆ EpiPen® can be found in:  Backpack  Waistpack  Other (specify) \_\_\_\_\_

**Field Trip Procedures – EpiPen® should accompany student during any off campus activities.**

- ◆ Student should remain with the teacher or parent/guardian during the entire field trip:  Yes  No
- ◆ Staff members on trip must be trained regarding EpiPen® use and student health care plan (plan must be taken).
- ◆ Other (specify)\_\_\_\_\_

**CLASSROOM –For Food allergy only**

- Foods approved by parent
- Middle school or high school student will be making his/her own decision.
- Alternative snacks will be provided by parent/guardian to be kept in the classroom.
- Parent/guardian should be advised of any planned parties as early as possible.
- Classroom projects should be reviewed by the teaching staff to avoid specified allergens.
- ◆ Other (specify):\_\_\_\_\_

**CAFETERIA**

- NO Restrictions**
- Student will sit at a specified allergy table in the cafeteria.
- ◆ Cafeteria manager should be alerted to the student’s allergy.
- ◆Other:\_\_\_\_\_

1.Parent/Guardian		H:	W:	C:
2.Parent/Guardian		H:	W:	C:
3. Other		H:	W:	C:
4. Other		H:	W:	C:

- ◆ I request this medication to be given as ordered by the licensed health care provider.
- ◆ I give Health Services Staff permission to communicate with the medical office about this medication. I understand the medication(s) will not necessarily be given by a school nurse (designated staff will be trained and supervised).
- ◆ Medical/Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- ◆ All medication supplied must come in its originally provided container with instructions as noted above by the licensed health care provider.
- ◆ I request and authorize my child to carry and/or self-administer their medication.\_\_\_\_ Yes \_\_\_\_ No
- ◆ Student demonstrated to the nurse the skill necessary to use an EpiPen \_\_\_\_ Yes \_\_\_\_N/A\_\_\_\_\_
- ◆ This permission to possess and self-administer an EpiPen® may be revoked by the principal/school nurse if it is determined that your child is not safely and effectively able to self-administer.
- ◆ EpiPen® auto-injectors exposed to temperatures below 59°F or above 86°F may not function properly. The auto-injector has not been tested below or above the United States Pharmacopeia Controlled Room Temperature standard. Parents may want to take EpiPens® home over extended winter breaks when thermostats are set below 59°F. The EpiPens® must be returned before the student returns to school.
- ◆ A copy of “Notice of Parent/Guardian and Student Rights for Section 504” was given to parent/guardian.\_\_\_\_Yes

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
School Nurse Signature

\_\_\_\_\_  
Date

A copy of the Health Care Plan will be kept in the substitute folder and given to all staff members who are involved with the student.  
A copy of “Notice of Parent/Guardian and Student Rights for Section 504” can be found at  
[www.issaquah.wednet.edu/documents/career/504\\_Parent-Student\\_Rights.pdf](http://www.issaquah.wednet.edu/documents/career/504_Parent-Student_Rights.pdf)