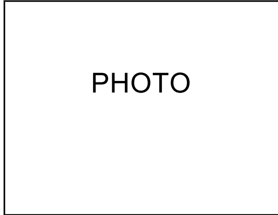
ALLERGY ACTION PLAN
Santa Cruz County Schools



Student Name:___________________________ DOB:________________ Asthma: Y / N

List All Allergies:____

PARENT – PLEASE PROVIDE EPINEPHRINE AUTO-INJECTORS WHICH WILL NOT EXPIRE DURING THE SCHOOL YEAR

I request that my child be allowed to take medication at school according to instruction from his physician. I understand it is my responsibility to bring the medication in the original pharmacy container labeled with student name, medication, dosage and directions (Ed Code 49423). I authorize school personnel to assist with this medication for my child as ordered by the physician. I understand trained, non-medical personnel may assist with or administer medication (Ed Code 49423 and 49480). I will notify the school of any changes in medication. I understand that the School Nurse may communicate with the Health Care Provider about this student when necessary.

____________________________________ ______________ ______________

Parent/Guardian Signature *Date* *Phone*

PHYSICIAN -- COMPLETE MEDICATION LIST BELOW AND *CHECK* ALL THAT APPLY

☐ **Epinephrine Auto-Injector** _____________________ **CIRCLE DOSE**: **Epinephrine 0.15 mg** **Epinephrine 0.30 mg**

☐ A SECOND DOSE OF EPINEPHRINE MAY BE GIVEN 10-15 MINUTES AFTER THE FIRST DOSE, IF SYMPTOMS PERSIST OR RECUR

☐ ***Antihistamine:** ______________________________ **Give by mouth DOSE:**_______________________________

☐ ***Inhaler:** ____________________________________ **DOSE**: ________________ **Puffs Every**_____________**Hours**

☐ If this box is checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms

SEVERE SYMPTOMS	ACTION
Any SEVERE SYMPTOMS after Suspected Ingestion/Exposure: **ONE OR MORE OF THE FOLLOWING** ▪ LUNG: Difficulty Breathing, Audible Wheezing, Difficulty Talking ▪ HEART: Pale, Blue, Faint, Dizzy, Confused, Weak Pulse ▪ THROAT: Tight, Hoarse, Trouble Breathing / Swallowing ▪ MOUTH: Significant Swelling of Tongue and Lips ▪ SKIN: Many Hives over Body, Widespread Redness ▪ G.I.: Repetitive Vomiting or Severe Diarrhea ▪ OTHER: Feeling something bad is about to happen, anxiety, confusion **OR a combination of mild or severe symptoms from different body areas**	**1. INJECT EPINEPHRINE IMMEDIATELY** **2. CALL 911** **3. BEGIN MONITORING (SEE BOX BELOW)** **4. GIVE ADDITIONAL MEDICATIONS IF ORDERED ABOVE * .** *Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE**

MILD SYMPTOMS ONLY	ACTION
Any MILD SYMPTOMS only: ▪ MOUTH: Itchy Mouth ▪ NOSE: Itchy, Runny Nose, Sneezing ▪ SKIN: A Few Hives, Mild Itch ▪ G.I.: Mild Nausea, Discomfort	**1. GIVE ANTIHISTAMINE, IF ORDERED ABOVE** 2. Stay With Student. Alert Office and Parent/Emergency Contacts **3. IF SYMPTOMS BECOME SEVERE, SEE ABOVE, USE EPINEPHRINE AND CALL 911** 4. Begin Monitoring (see box below)

MONITORING

1. Stay with student
2. Tell paramedic Epinephrine was given, **note time**. If a second dose is given, **note time**.
3. For a severe reaction: **KEEP STUDENT HORIZONTAL -- LEGS RAISED -- TURN ON SIDE IF NAUSEOUS**
4. A second dose of Epinephrine may be given 10-15 minutes after the first dose, if checked above.
5. **If breathing stops at any time during the procedure initiate CPR immediately.**

☐ **Student to carry medication and self-administer.** The health care provider has confirmed that the student is capable of appropriate self-administration of the above medication. If student is younger than 18, the parent/guardian assumes all liability related to this patient's use, timing and technique in self-administering this medication.

Physician Signature:____________________________________ Date:______________

Student Contract for Carrying Own Medication: I will be responsible for carrying, administering, and keeping my medication safe at all times. I will use the medication in the way prescribed by my physician. I will not show or share my medication with other students. I will immediately report to persons in charge if my medication is missing. Signed: ____