

**RSU 10
Allergic Reaction Emergency Action Plan**

Student: _____ Date of Birth: _____

Grade: _____ Teacher: _____

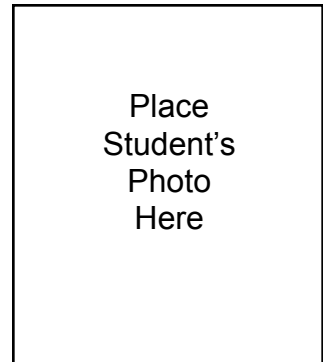
Diagnosis of asthma: No Yes (associated with higher risk for severe reaction)

My child's allergic reaction triggers are (please explain):

- | | | | |
|--------------------------------------------------|-------------------------------------|----------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Chocolate | <input type="checkbox"/> Almond | <input type="checkbox"/> Peanut | <input type="checkbox"/> Insect sting |
| <input type="checkbox"/> Egg | <input type="checkbox"/> Brazil Nut | <input type="checkbox"/> Pecan | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Fish | <input type="checkbox"/> Cashews | <input type="checkbox"/> Pistachio Nut | <input type="checkbox"/> Medication (please list) |
| <input type="checkbox"/> Fruit (please list) | <input type="checkbox"/> Coconut | <input type="checkbox"/> Tree nut | |
| <input type="checkbox"/> Food additive | <input type="checkbox"/> Hazelnut | <input type="checkbox"/> Walnut | |
| <input type="checkbox"/> Shellfish | <input type="checkbox"/> Macadamia | <input type="checkbox"/> Seeds (poppy, sunflower, other) | |
| <input type="checkbox"/> Vegetable (please list) | | | |

Other (list): _____

Explanation: _____



RECOGNITION AND TREATMENT

To be completed by Health Care Provider ONLY		Give CHECKED Medication	
<i>If food ingested or contact with allergen occurs:</i>		EPINEPHRINE	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 blood pressure, fainting, pale, blueish color		
NEURO*	Disorientation, dizziness, loss of consciousness		
If reaction is progressing (several of the above areas affected) GIVE:			
* POTENTIALLY LIFE THREATENING			
The severity of symptoms can quickly change.			

Epinephrine: EpiPen Jr.® EpiPen® Twinject® 0.15 mg Twinject® 0.3 mg





Antihistamine (Benadryl®) 12.5 mg 25 mg 50 mg

Other medication(s): _____

EMERGENCY CONTACTS

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

Physician signature: _____ **Date:** _____

<p>EpiPen® and EpiPen® Jr. Directions</p> <ul style="list-style-type: none"> ▪ Pull off gray activation cap.  <ul style="list-style-type: none"> ▪ Hold black tip near outer thigh (always apply to thigh).  <ul style="list-style-type: none"> ▪ Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds. 	<p>Twinject® 0.3 mg and Twinject® 0.15 mg Directions</p>  <ul style="list-style-type: none"> ▪ Remove caps labeled "1" and "2." ▪ Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove. <p>SECOND DOSE ADMINISTRATION: If symptoms don't improve after 10 minutes, administer second dose:</p> <ul style="list-style-type: none"> ▪ Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base. ▪ Slide yellow collar off plunger. ▪ Put needle into thigh through skin, push plunger down all the way, and remove. 
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Parent/Guardian Agreement and Authorizations

- I will provide the school with any medication which my child requires for emergency treatment.
- I will initiate a meeting with the school nurse and School Nutrition Director to determine menu options for my child who has a food allergy.
- I will educate my child in self-management of his/her food allergy including safe and unsafe foods, strategies for avoiding exposure to unsafe foods, symptoms of an allergic reaction, and how and when to tell an adult if he/she may be having an allergy related problem.
- I want this allergy plan implemented for my child; **I want my child to carry an auto-injector** 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 an auto-injector.
- I want this plan implemented for my child and I **do not** want my child to self-administer epinephrine.

Your signature gives permission for the school nurse to contact and receive additional information from your 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 auto-injector and allergy medication and understand the signs and symptoms for which they are given.
- I agree to carry my auto-injector with me at all times.
- I will notify a responsible adult (teacher, nurse, coach, etc.) **IMMEDIATELY** when my auto-injector is used.
- I will not share my medication with other students, leave my auto-injector unattended, or use my auto-injector in an inappropriate manner.
- I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature: _____ Date: _____

Nurse Signature: _____ Date: _____