WYLIE INDEPENDENT SCHOOL DISTRICT

ALLERGY/ANAPHYLAXIS ACTION PLAN

Student Name _____ **D.O.B.** _____ **Teacher**_____

Health Care Provider _____ **Preferred Hospital** _____

Student Photo

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

- ☐ **History of Asthma (Increased risk of severe reaction)**
- ☐ **Foods (list):**
- ☐ **Medications (list):**
- ☐ **Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)**
- ☐ **Stinging Insects (list):**

RECOGNITION AND TREATMENT

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. GIVE ANTIHISTAMINE
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

MONITORING AND EMERGENCY CALLS

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call parents/guardian to notify of reaction, treatment and student's health status.
3. Notify school if student is not on campus
4. Stay with student until EMS arrives. A second dose (if available) can be given 5 minutes or more after the first if severe symptoms persist or recur.

MEDICATION

Epinephrine: Inject into outer thigh Check one:. ☐ **Injectable Epinephrine 0.3 mg**
☐ **Injectable Epinephrine 0.15 mg**

Antihistamine: To be given by mouth o*nly if able to swallow.* **Brand/Dose**_____

Other (inhaler/bronchodilator if asthmatic)_____

☐ This child has received instruction in the proper use of the EpiPen. It is my professional opinion that this student **SHOULD** be allowed to carry and use the EpiPen independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the EpiPen is self-administered.
☐ It is my professional opinion that this student **SHOULD NOT** carry the EpiPen.

Health Care Provider Signature _____ **Phone:** _____ **Date** _____

Student/Parent/Guardian Agreement (check boxes to indicate agreement):

☐ I have been trained in the use of my EpiPen (or other auto-injector epinephrine) and prescribed allergy medication and understand the signs and symptoms for which they are to be given.

☐ I know it is my responsibility to keep my medication with me so that it is easily accessible in case of an emergency during school hours, extracurricular activities and field trips.

☐ I will notify a responsible adult (teacher, nurse, coach, etc.) **IMMEDIATELY** when EpiPen is used.

☐ I will not share my medication, leave my EpiPen unattended, or use my medications for any other use that for which it is prescribed.

☐ I will inform the school nurse and my parents if my medication is lost, stolen, or has expired.

☐ I would like for my classmates and/or their parents to be aware of my food allergy.

Before/after school programs/extracurricular activities: ☐ AlphaBest ☐ Athletics ☐Band ☐ Drill Team ☐Cheer ☐Other (list): _____

It is recommended that backup medication be stored with the school/ school nurse in case a student forgets or loses EpiPen and/or antihistamine. The school district is not responsible or liable if backup medication is not provided to the school/ school nurse and student is without working medication when medication is needed.

Your signature gives permission for the nurse to implement this action plan and to contact and receive additional information from your health care provider regarding the allergic condition(s) and the prescribed medication. Anaphylaxis Action Plan will be shared with school personnel with legitimate educational interest.

Parent/Guardian Signature: _____Phone: _____ Date_____

Student Signature (if self-administering):_____Backup medication stored at school? ☐ Yes ☐ No

PREVENTION: Avoidance of allergen is crucial to prevent anaphylaxis. Critical components to prevent life threatening reactions: Initial indicates activity completed by school staff

	Encourage the use of Medic-alert bracelets
	Notify nurse, teacher(s), front office and kitchen staff of known allergies (include substitutes)
	Avoid use of latex containing products in schools (balloons,gloves)
	Consider food and safety provisions while off campus (field trips)
	Discourage allergen containing snacks
	Encourage allergen aware zone(s) in the school cafeteria
	Other:

DIRECTIONS FOR EPIPEN® AND INITIAL TWINJECT USE

1. Remove activation cap or release.
2. Hold auto-injector tip (black or orange) to outer thigh (apply to thigh **only**).
3. Press hard into outer thigh until auto-injector mechanism functions. Hold in place for 10 seconds.
4. Remove. Massage for 10 seconds.
5. Call 911/EMS.

STAFF MEMBERS TRAINED

Name	Title	Location/Room #	Trained By

EMERGENCY CONTACTS

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

Approved by Nurse Signature: _____Date _____