

Resurrection St. Paul Allergy Medication Form and Action Plan

Student Name _____ D.O.B. _____ Gender ___ School Year _____

ALLERGY TO _____

Check all that apply: _____ ingestion _____ touch/contact _____ sting/bite _____ other (list) _____

TREATMENT

Symptoms:

Give checked medicine**:

** determined by physician authorizing treatment
Give Epinephrine first if both are checked

- . If student has had contact with or touched allergen, but **no** symptoms (wash area with soap and water and observe for symptoms) _____ Epinephrine _____ Antihistamine
- . If allergen has been ingested, but **no** symptoms _____ Epinephrine _____ Antihistamine
- . Skin Hives, itchy rash, swelling of face or extremities _____ Epinephrine _____ Antihistamine
- . Mouth Itching, tingling, **swelling of lips, tongue, mouth** _____ Epinephrine _____ Antihistamine
- . Gut Nausea, abdominal cramps, vomiting, diarrhea _____ Epinephrine _____ Antihistamine
- . Throat **Tightening of throat, hacking cough, voice changes** _____ Epinephrine _____ Antihistamine
- . Lung **Shortness of breath, repetitive coughing, wheezing** _____ Epinephrine _____ Antihistamine
- . Heart **Weak pulse, lightheaded, pale, blueness, fainting** _____ Epinephrine _____ Antihistamine
- . If reaction is progressing (if two or more of the above areas affected), give (The **bolded** symptoms are potentially life threatening) _____ Epinephrine _____ Antihistamine

MEDICATION

Epinephrine: inject intramuscularly (circle one) **EpiPen Jr. 0.15 mg** **EpiPen 0.30 mg**
(*Give in lateral thigh. See reverse side for injection instructions)

Antihistamine: give _____
Medication/strength/dose/route/frequency

Other: give _____
Medication/strength/dose/route/frequency

Check all that apply: _____ student requires additional EpiPen in the classroom _____ student may carry EpiPen on self
Or in backpack
_____ student may self administer EpiPen (after appropriate training)

EMERGENCY CONTACTS

Name/Relationship	Phone Numbers
_____	_____
_____	_____

Provider's signature _____ **Printed name or stamp** _____ **Date** _____

Providers Phone number _____ **Parent Signature** _____ **Date** _____
(kss 5/07)

TRAINED STAFF MEMBERS

- 1. _____ Room _____
- 2. _____ Room _____
- 3. _____ Room _____

Once EpiPen® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

EpiPen® and EpiPen® Jr. Directions

- 1. Pull off gray activation cap.**
- 2. Hold black tip near outer thigh (always apply to thigh).**
- 3. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions.**
- 4. Hold in place and count to 10.**
- 5. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

Oral medication administration					
_____	_____	_____	_____	_____	_____
Medication	Dose	Date	Time	Symptoms	Signature
_____	_____	_____	_____	_____	_____
Medication	Dose	Date	Time	Symptoms	Signature

EpiPen administration					
_____	_____	_____	_____	_____	_____
Medication	Dose/Site L/R	Date	Time	Symptoms	Signature
_____	_____	_____	_____	_____	_____
Medication	Dose/Site L/R	Date	Time	Symptoms	Signature