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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		___Epinephrine ___Antihistamine

MEDICATION

Epinephrine: inject intramuscularly (check one)

____Epinephrine auto-injector 0.15 mg **____Epinephrine auto-injector 0.30 mg**

Antihistamine: give_____
Medication/strength/dose/route/frequency

Other: give_____
Medication/strength/dose/route/frequency

Check all that apply:

____Student requires additional epinephrine auto-injector in the classroom

____Student may carry epinephrine auto-injector in backpack

____Student may carry auto-injector (after appropriate training)

____Student may self-administer auto-injector

EMERGENCY CONTACTS

Name/Relationship	**Phone Numbers**	
_____	_____	_____
_____	_____	_____

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

Providers Phone number_____ **Parent Signature**_____ **Date**_____

(Prescriber Address Stamp)

Once epinephrine is used, call 911. Take the used auto-injector with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

EpiPen® and EpiPen® Jr. Directions

1. Pull off blue safety release.

2. Swing the pen and firmly push orange tip against outer thigh
So it "clicks."

4. Hold in place on thigh and count to 10 to deliver drug.

5. Remove the EpiPen® unit and massage the injection area for 10 seconds.

6. Seek medical attention.

Auvi-Q and Allerject Directions

1. **Pull off red safety guard.**
2. **Place black end against outer thigh.**
3. **Then press firmly and hold in place for 5 seconds.**
4. **Remove from the thigh and massage the injection area for 10 seconds.**
5. **Seek medical attention.**

Oral medication administration

Medication	Dose	Date	Time	Symptoms	Signature

Epinephrine administration

Medication	Dose/Site L/R	Date	Time	Symptoms	Signature

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