Winfield R-IV School District
Allergy Action Plan
Emergency Care Plan

Place Student's Picture Here

TO BE COMPLETED BY PARENT

Student:_____ **D.O.B.:** _____ **Teacher/Grade**_____

Extremely reactive to the following: _____

Weight: _____ lbs. **Asthma:** ☐ Yes* ☐ No *__higher risk for a severe reaction__

TO BE COMPLETED BY HEALTHCARE PROVIDER

ANY SEVERE SYMPTOMS:
(to be determined by physician authorizing treatment)

- ☐ **Mouth** Itching, tingling, swelling of the lips, tongue or mouth
- ☐ **Skin** Hives, itchy rash, swelling of face or extremities
- ☐ **Gut** Nausea, abdominal cramps, vomiting, diarrhea
- ☐ **Throat** Tightness of throat, hoarseness, hacking cough
- ☐ **Lung** Shortness of breath, repetitive coughing, wheezing
- ☐ **Heart** Weak pulse, low blood pressure, fainting, pale, blueness
- ☐ **Other** _____

INJECT EPINEPHRINE IMMEDIATELY

Call 911

Give additional medication(s) as ordered:

_____

_____

MILD SYMPTOMS ONLY:
(to be determined by physician authorizing treatment)

- ☐ **Mouth** Itching
- ☐ **Skin** A few hives, itchy rash
- ☐ **Gut** Mild nausea/discomfort
- ☐ **Other** _____

GIVE ANTIHISTAMINE AS ORDERED

Stay with student; alert healthcare professionals and parent

If symptoms progress to severe USE EPINEPHRINE

List Known Medical Conditions, Medications & Allergies: _____

_____

Medications/Doses:

Epinephrine (brand/dose/frequency):_____

Antihistamine (brand/dose/frequency):_____

Other (e.g., inhaler-bronchodilator if asthmatic):_____

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

_____	_____	_____	_____
Physician/Healthcare Provider (Print)	Physician/Healthcare Provider (Signature)	Date	Phone number

Parent/Guardian Authorization and Permission for Release of Information

1. I give permission for the above information to be shared in confidence with appropriate staff and emergency personnel. In the event of an emergency, I authorize school personnel to obtain emergency medical care and/or emergency transportation by ambulance to the hospital.
2. I give permission for the school nurse to contact my child's health care provider to obtain any medical information pertaining to my child's allergy.
3. I request that the above medication(s) be sent on field trips.
4. I agree with the above Allergy Action Plan and give permission for the medication(s) to be given by school personnel as delegated, trained, and supervised by the school nurse.

_____	_____	_____
Parent/Guardian (Print)	Parent/Guardian (Signature)	Date

TURN FORM OVER

CALL 911 AFTER ADMINISTERING EPINEPHRINE

Any remaining epinephrine after fixed dose cannot be further used and must be discarded.

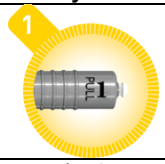
- Put the injector, needle first, into its carrying case
- Close the case top over the non-needle end of the injector
- Injector pens are NOT to be thrown away in a trash can
- Give them to a healthcare professional for proper disposal

Remember, if you forget how to use the **EpiPen® or **Adrenaclick**® easy-to-follow instructions are printed on the side of the injector!*

Monitoring

- Stay with student
- Alert healthcare professionals and parent.
- Tell rescue squad epinephrine was given; request an ambulance with epinephrine.
- Note time when epinephrine was administered.
- For a severe reaction, consider keeping student lying on back with legs raised.
- Treat student even if parents cannot be reached.

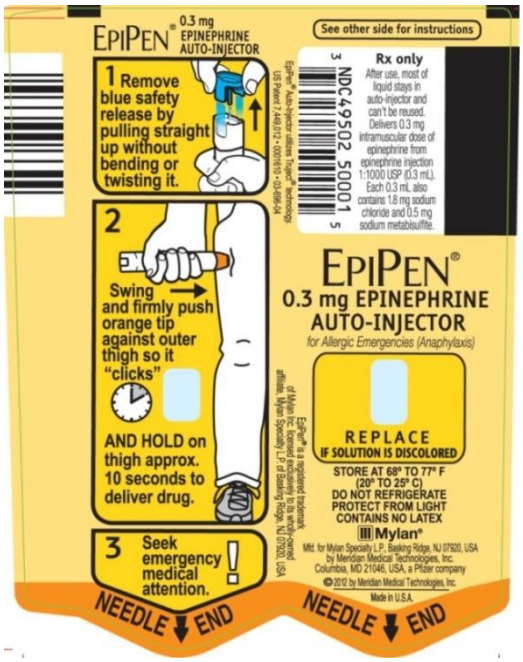
How to use Adrenaclick®: Easy as…



Remove the GRAY cap labeled "1". Never put thumb, finger, or hand over the RED tip

Remove the GRAY cap labeled "2"

Place RED tip on the middle of the outer side of the thigh. Press down hard until the needle penetrates the skin and slowly count to 10



EMERGENCY INFORMATION

Student Name: _____

Parent Name:_____

Address:_____

City: _____State: _____ Zip:_____

Home Phone: _____

Alt. Phone Number: _____

EMERGENCY CONTACTS

Name:_____

Phone:_____

Relationship: _____

Name:_____

Phone:_____

Relationship: _____

FOR SCHOOL PERSONNEL ONLY

- ❖ **Medication authorization complete** ☐ **YES** ☐ **NO For:**_____
- ❖ **Medication maintained in nurse office** ☐ **YES** ☐ **NO For:**_____
- ❖ **Medication self-carried** ☐ **YES** ☐ **NO For:**_____
- ❖ **Copies of Action Plan provided to:** **Teacher(s)** ☐ **YES** ☐ **NO** **Principal's Office** ☐ **YES** ☐ **NO**
  Athletic ☐ **YES** ☐ **NO** **Food Service** ☐ **YES** ☐ **NO**
- ❖ **Staff trained in medication administration** ☐ **YES** ☐ **NO**

School Personnel (Print)	School Personnel (Signature)	Date

FULL ALLERGY PLAN HAS BEEN IMPLEMENTED

Nurse Signature	**Nurse Signature**	**Date**