Springs CHARTER SCHOOLS
HEALTH SERVICES DEPARTMENT

Allergy Action Plan

Effective Date: _____

Student Name: _____ DOB: _____ Grade: _____

Site/Program: _____

Parents/Guardian Information:	Relationship:	Phone Number(s):
1)		
2)		

ALLERGIC TO THESE ALLERGENS: _____

I give permission for my child's school site/nurse to notify appropriate staff members of my child's diagnosis, as well as give permission for the school to implement this plan of care for my child, and that any medical orders supersede district plans.

Parent/Guardian Signature: _____ Date: _____

This portion to be completed by Physician

☐ Student may carry allergy medication ☐ Student may self- administer allergy medication

PHYSICIAN TO COMPLETE

☐ Has Asthma (increases risk for severe reaction)
☐ Severe allergy previously/suspected- **Immediately give epinephrine & call 911** –Start with Steps 2 & 3

STEP 1: IDENTIFICATION OF SYMPTOMS

Symptoms: **Send for immediate adult assistance		Type of Medication to Give: (Determined by physician authorizing treatment)	
Lung**	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
Heat**	Faint, pale, blueness around mouth or nail beds, weak pulse, low B/P	☐ Epinephrine	☐ Antihistamine
Throat	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
Other**		☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affected) give		☐ Epinephrine	☐ Antihistamine
If exposed to allergen, or allergen ingested, but no symptoms. **Potentially life-threatening – Note: Severity of symptoms can quickly change.		☐ Epinephrine	☐ Antihistamine

STEP 2: GIVE MEDICATION

Epinephrine: inject intramuscularly (check one) ☐ EpiPen® 0.3mg ☐ EpiPen Jr® 0.15mg

- **If Epinephrine is given, paramedics must be called! PROCEED TO STEP 3 BELOW.**

Antihistamine/Other: give _____ (Medication name & amount) **by** _____ (route/method)

- **Notify** parents. **Observe** for increasing severity of symptoms. **Call 911** as needed.

IMPORTANT: Do NOT depend on asthma inhalers and/or antihistamines to replace epinephrine in a severe reaction. EpiPen Directions:

STEP 3: EMERGENCY CALLS

1. **CALL 911**– *Seek emergency care*. State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Call Parents or Emergency Contacts

Physician Name (printed): _____ Phone Number: _____

Physician Signature: _____ Date: _____ License #:_____

Return Fax: 951-489-0494 or Email: school.nurse@springscs.org