ALLERGY ACTION PLAN

USE 1 FORM PER CHILD FOR EACH ALLERGEN

Student _____School_____.

DOB _____ Age_____ Weight _____ Grade/Rm _____

Allergy to _____

Student Photo

Student has asthma. ❑ Yes ❑ No (If yes, higher chance of severe reaction)
Student has had anaphylaxis. ❑ Yes ❑ No
Student may carry epinephrine. ❑ Yes ❑ No (if yes, complete next page)
Student may give him/herself medicine. ❑ Yes ❑ No (If student refuses/is unable to self-treat, an adult must give medicine.)

IMPORTANT REMINDER

Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

❑ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:
- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): _____Dose:❑ 0.15 mg ❑ 0.30 mg (weight more than 55 lbs.)
Antihistamine, by mouth (type and dose): _____
Other (for example, inhaler/bronchodilator if student has asthma): _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

Emergency Contacts/Relationship Telephone number

1._____ _____
2._____ _____
3._____ _____

University Hospitals
Reviewed by Dr. Carly Wilbur 4/2019

******(To be completed ONLY if student will be carrying an Epinephrine Autoinjector)******

AUTHORIZATION FOR STUDENT POSSESSION AND USE OF AN EPINEPHRINE AUTOINJECTOR

(In accordance with ORC 3313.718/8313.141)

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

Parent/Guardian signature	Date
Parent/Guardian name	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the medication prescriber.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Circumstances for use of the epinephrine autoinjector
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the prescriber)
To a student for which it is **not** prescribed who receives a dose

Special instructions

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ( )

Developed in collaboration with the Ohio Association of School Nurses.

HEA 4222 3/07

Chagrin Falls Exempted Village Schools

FOOD ALLERGY Exposure Control Plan

(To be completed by parent/guardian and returned to School Clinic with the Allery Action Plan)

Student Name_____Grade_____ Teacher_____

Allergic to: _____

Date & description of last reaction: _____

TRANSPORTATION - Student will generally ride the bus? Yes _____ No_____

- If YES, AM Bus# _____, PM Bus# _____

EPINEPHRINE AUTOINJECTOR (epipen, adreniclick, Auvi Q, etc.) Does student self-carry an epipen? (Upon school receipt of a completed ODH AUTHORIZATION FOR STUDENT POSSESSION AND USE OF AN EPINEPRHINE AUTOINJECTOR, in accordance w ORC 3317.718/8313.141).
Yes_____ No_____

- If YES, list ALL places student will keep their epipen(s), e.g. backpack, gym bag, purse, etc.:_____

CLASSROOM - Parent/guardian encouraged to contact teacher for information re: field trips, anticipated class snacks, treats, party menus. Parent/guardian may consider providing a supply of safe alternative snacks to the classroom teacher.

CAFETERIA /LUNCH ROOM

1. Is this student permitted to purchase food in the lunch room (check one)?:
   - _____ Yes – no restrictions
   - _____ Yes – with restrictions - ***Contact Food Service Supervisor, Marti Jacobson, MS RD LD @ 440-247-5500 x4492 or Marti.Jacobson@chagrinschools.org***
   - _____ NO – no food/beverage purchases permitted – ***Contact Food Service Supervisor, Marti Jacobson, MS RD LD @ 440-247-5500 x4492 or Marti.Jacobson@chagrinschools.org***

2. **MUST** this student sit at the Nut Free Table? Yes_____ No_____

Parent/Guardian Signature:_____Date_____

Clinic Staff Signature: _____Date_____