Millville Public Schools - Allergy Action Plan

Student's Name: _____ D.O.B: _____ Teacher/Homeroom: _____

ALLERGY TO: _____

Asthmatic: Yes * No Higher risk for severe reaction

STEP 1 : PREVENTION

Avoid contact with: _____ □ ingestion □ inhaled □ skin contact □ other: _____

The following foods may be substituted: _____

Preferential seating in the cafeteria, □ No □ Yes Describe: _____

_____

Preferential seating on the school bus, □ No □ Yes Describe: _____

STEP 2: TREATMENT

Symptoms:		**Give Checked Medication:** (To be determined by healthcare provider authorizing treatment)	
Contact with allergen but *no symptoms:*		□ 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
Throat	Tightening of throat, hoarseness, hacking cough	□ Epinephrine	□ Antihistamine
Lung	Shortness of breath, repetitive coughing, wheezing	□ Epinephrine	□ Antihistamine
Heart	Thready pulse, low blood pressure, fainting , pale, blueness	□ Epinephrine	□ Antihistamine
Other	_____	□ Epinephrine	□ Antihistamine
If reaction is progressing (several of the above areas affected), give:		□ Epinephrine	□ Antihistamine

Dosage:

Epinephrine: inject intramuscularly (circle one): EpiPen® EpiPen®Jr. Twinject™ 0.15 mg

Antihistamine: give: _____
(medication/dose/route)

Other: _____
(medication/dose/route)

To be completed by the ordering physician:

□ This student is capable and has been instructed in the proper method of self-administering the medications named above.

□ This student is **not** approved to self-medicate.

Doctor's Signature: _____ Date: _____

STEP 3: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and an additional epinephrine may be needed.
2. Dr. _____ at _____.
3. Emergency contacts: To be completed by parent/guardian.

	Name/Relationship	Phone number(s)	
a.	_____	1. _____	2. _____
b.	_____	1. _____	2. _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, MEDICATE AND TRANSPORT STUDENT TO A MEDICAL FACILITY

I have read and understand the Allergy Action Plan created for my child. I understand that it will be shared verbally and/or in writing with school personnel involved with my child. I acknowledge that the Millville Public Schools and its employees and agents shall incur no liability as a result of any injury arising from self-administration of medication by the student. I agree to indemnify and hold harmless the school district and its employees and agents against any claims arising from self-administration of life-saving medication by the student.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____