School:_____
Year:_____

Grade:_____

ALLERGY ACTION PLAN

NAME:_____ **DOB:**_____

ALLERGY TO:_____ **ASTHMA:** ❑ Yes (higher risk for a severe reaction) ❑ No

MILD SYMPTOMS ONLY: MOUTH: Itchy mouth SKIN: A few hives around mouth/face, mild itch GUT: Mild nausea/discomfort	1. **GIVE ANTIHISTAMINE** 2. Stay with student; alert healthcare professionals and parent 3. If symptoms progress (see below), USE EPINEPHRINE, monitor
Any **SEVERE SYMPTOMS** after suspected or known ingestions: One or more of the following: LUNG: Short of breath HEART: Pale, blue, faint, weak pulse, dizzy, confused THROAT: Tight, hoarse, trouble Breathing/swallowing MOUTH: Obstruction swelling (tongue and/or lips) SKIN: Many hives over body Or **combination** of symptoms from different body areas: SKIN: Hives, itchy rashes, swelling (e.g., Eyes, lips) GUT: Vomiting, crampy pain	1. **INJECT EPINEPHRINE IMMEDIATLY** 2. Call 911 3. Begin monitoring 4. Give additional medications. - Antihistamine - Inhaler (bronchodilator) if asthmatic *** Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a (severe reaction) anaphylaxis. USE EPINEPHRINE.**

Per KRS 158.834 and KRS 158.836 the student may carry and self-administer medications to treat anaphylaxis when at school or at a school sponsored activity. As this student's health care provider, I have instructed this student in appropriate self-administration. The student will be expected to carry and use his/her medications responsibly. ❑Yes* ❑No**

MEDICATIONS/DOSAGE

Epinephrine (brand and dose): _____
Antihistamine (brand and dose):_____
Other (e.g., inhaler-bronchodilator if asthmatic): _____

CONTACTS

CALL 911 (Rescue Squad): (___)___-____ Doctor:_____ Phone: (___)___-____ Parent/Guardian: _____ Phone: (___)___-____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian hereby acknowledges that if this medication is not self-administered, it will most likely be administered by trained, unlicensed WCPS personnel. By signing this form, the parent/guardian shall acknowledge that the Warren County Board of Education and its employees shall incur no liability as a result of any injury sustained by the student from self-administration of his/her medications to treat asthma or anaphylaxis and the parent/guardian shall indemnify and hold harmless the school and its employees against any claims relating to the self-administration of such medication.

Parent/Guardian Signature:_____ Date:_____

Doctor's Signature:_____ Date:_____
(Required)

Telephone number:_____ Fax:_____

***No epi-pen will be transported on a bus unless the parent/guardian makes specific arrangements with the school.**