



Individual Health Plan (IHP) Severe Allergy Emergency Action Plan

Name of Student: _____ Date of Birth: _____

School: _____ School Year: _____ Grade: _____

Parent/Guardian: _____ Phone Number: _____

Asthma: YES NO (Yes = Higher risk for severe reaction)

Exposure to allergen with no symptoms	Give epinephrine immediately: <input type="checkbox"/> YES <input type="checkbox"/> NO Give antihistamine immediately: <input type="checkbox"/> YES <input type="checkbox"/> NO See below for dosage
Any Severe Symptoms after suspected or known exposure:	Actions
<p>One or more of the following: LUNG: Shortness of breath, wheezing, repetitive cough HEART: Pale, blue, faint, weak pulse, dizzy THROAT: Feels tight, hoarse, trouble breathing/swallowing MOUTH: Significant swelling of the tongue/lips SKIN: Many hives over body, widespread redness GUT: Repetitive vomiting, severe diarrhea OTHER: Feeling something bad is about to happen, anxiety, confusion</p> <p>OR MORE THAN ONE MILD SYMPTOM: NOSE: Itchy/runny nose, sneezing MOUTH: Itchy mouth SKIN: A few hives, mild itch GUT: Mild nausea/discomfort</p>	<ol style="list-style-type: none"> INJECT EPINEPHRINE IMMEDIATELY <input type="checkbox"/> 0.3 mg Yellow Box <input type="checkbox"/> 0.15 mg Green Box Call 911 Give additional medications if available: <ul style="list-style-type: none"> Antihistamine Inhaler Lay the person flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side. If symptoms do not improve, or symptoms return, another dose of epinephrine can be given about 5 minutes or more after the last dose. Alert emergency contacts Student should be transferred to the emergency room by EMS because symptoms may return
Mild Symptoms ONLY:	Actions
<p>NOSE: Itchy/runny nose, sneezing MOUTH: Itchy mouth SKIN: A few hives, mild itch GUT: Mild nausea/discomfort</p>	<ol style="list-style-type: none"> GIVE ANTIHISTAMINE if provided and ordered by doctor. _____ For mild symptoms from more than one area, give epinephrine. Stay with person and alert emergency contacts. Watch closely for changes. If symptoms worsen, give epinephrine. Do not depend on antihistamines. When in doubt, give epinephrine and call 911.

Medication Authorization Received: Yes No If NO use stock epinephrine. Student weight: _____

Location of Epinephrine injector: _____ Location of antihistamine: _____

Date Epi received: _____ Expiration Date: _____ # of doses available: _____

Date antihistamine received: _____ Expiration Date: _____ # of doses available: _____

Student authorized to self-medicate and self-carry: YES NO

Location of back-up Epi: _____

Medication Picked up by _____ Date: _____

School Nurse Signature _____ Date: _____

Staff trained in severe allergy action plan, medication administration and documentation:			
Signature	Print and Initials	Trainer Name	Date

Attach Instructions for Use