**Allergy Action Plan**

**Place Student’s Picture Here**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B \_\_\_/\_\_\_\_\_/\_\_\_\_**

**Campus: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_**

**Severe Allergy to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Weight \_\_\_\_\_\_\_** lbs. **Asthma:** Yes(higher risk for a severe reaction) No

**Mild Symptoms Treatment Plan**

If the patient experiences **MILD** symptoms of (check those that apply):

* Several hives
* Itchy skin
* Swelling at site of insect sting but no other symptoms
* You suspect an accidental ingestion of an ingredient/drug/food that the child is allergic to but no other symptoms
* You suspect a sting by an insect that the child is allergic to but no other symptoms
* Swelling at the site of an allergy shot but no other symptoms

**Please give the following treatment:**

1. Send the child to the health room accompanied by an adult.
2. Give the following medication and dose to the patient by mouth:
   1. OTC Benadryl (Diphenhydramine) 12.5 mg 25mg 50mg
   2. Other Antihistamine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. Benadryl/antihistamine may be administered Q \_\_\_\_\_\_\_\_ hours if symptoms persist.
   4. Inhaler (brand / dose / frequency) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Contact the parent or emergency contact person.
4. Stay with the child and monitor symptoms.
5. Watch for more serious symptoms. If Moderate/Serious symptoms develop see action plan below.

**Moderate / Severe Symptoms Treatment Plan**

**Antihistamines and inhalers are not to be depended upon to treat a severe reaction. USE EPINEPHERINE.**

If the child experiences **MODERATE/SEVERE** symptoms of:

* Generalized hives/redness over the body / severe itchy skin
* Trouble breathing, trouble swallowing, a tight feeling, hoarseness, repetitive cough
* Swelling of the face, tongue, lip, neck, throat, or eyelids
* Vomiting, nausea, diarrhea, crampy pain
* Pale, blue, faint, weak pulse, dizzy, confused, clammy skin, loss of consciousness

**Please give the following treatment in this order:**

1. Give Epinephrine 0.3mg Epinephrine 0.15mg

**Epinephrine may be given through clothing. Instructions are on back page.**

1. Call 911 immediately
2. Call parents or emergency contact person
3. Monitor
4. Give Benadryl, other antihistamine, or inhaler as ordered above YES NO
5. If not improved give second dose of Epinephrine in \_\_\_\_\_\_\_\_ minutes YES NO

I request and authorize the Lewisville ISD to administer the above medication as prescribed. I understand that the school administrator may designate any qualified person or persons to administer this medication.

*This form is valid for one school year. Physician/Dentist must be licensed to practice in Texas. Temporary (2 months) orders for out of state US Physicians are acceptable to initiate treatment for transferring students.* *A signature is required to authorize the registered nurse and the prescribing physician to discuss and/or clarify the medication order and the student’s response to the treatment plan.*

**Elementary students are not permitted to transport medications to and from school.**

**Unused medications not picked up at the end of the school year will be disposed of properly.**

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Parent/Guardian Signature Date Physician/Healthcare Provider Signature Date

Office Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**

Revised 4/2013

**TURN FORM OVER**