Abundant Life Academy
Life-Threatening Allergy Action Plan

PART 1: TO BE COMPLETED BY PHYSICIAN

Student Name: ______________________ DOB: __________ Grade/Teacher: ______________

ALLERGY TO: ______________________________________

DIAGNOSIS: ______________________________________

STEP 1: TREATMENT

SYMPTOMS:	GIVE CHECKED MEDICATION:	
• If a food allergen has been ingested, but there are NO symptoms	____ Epinephrine	____ Antihistamine
• Mouth: itching, tingling, or swelling of lips, tongue, and mouth	____ Epinephrine	____ Antihistamine
• Skin: hives, itchy rash, swelling of face or extremities	____ Epinephrine	____ Antihistamine
• Gut: nausea, abdominal cramps, vomiting, and diarrhea	____ Epinephrine	____ Antihistamine
• Throat: tightening of throat, hoarseness, hacking cough	____ Epinephrine	____ Antihistamine
• Lungs: shortness of breath, repetitive coughing, wheezing	____ Epinephrine	____ Antihistamine
• Heart: thready pulse, low blood pressure, fainting, pale, blue	____ Epinephrine	____ Antihistamine
• Other: ______________________		
• If reaction is progressing (several of the above areas affected), give [The severity of symptoms can quickly change and be potentially life-threatening.]	____ Epinephrine	____ Antihistamine

IF THERE IS INADEQUATE RESPONSE TO THE FIRST DOSE OF EPI INJECTION WITHIN 10 MINUTES, ADMINISTER A SECOND DOSE.

MEDICATION:

Epinephrine: Inject intramuscularly (CHECK ONE) ____ **Epi-Pen 0.3 mg** ____ **Epi-Pen Jr. 0.15 mg** ____ **Other**

Antihistamine: Give ______________________________________
(Medication/Dosage/Route)

CHECK ALL THAT APPLY:

_______ Student has been trained in Epi-Pen administration and is both capable and responsible to self-administer Epinephrine. (see reverse)

_______ Student has been instructed in symptom recognition, is capable of, and may self-administer antihistamine. (see reverse)

_______ The antihistamine may be omitted from the above plan on a field trip in the absence of an authorized licensed staff member and when the student is not capable of administering it. (The parent has the option of accompanying child and administering an antihistamine, if necessary, on the field trip.)

In the absence of the school nurse, the order for the antihistamine should be disregarded and Epinephrine should be administered by the designated substitute.

STEP 2: EMERGENCY CALLS

1. Call 911 to request paramedics: State that an allergic reaction has been treated with epinephrine, and that additional epinephrine may be needed.
2. Call Doctor ____________________ at ________________________.
3. Call Emergency Contacts listed on the reverse side.

If a parent or caregiver cannot be reached, do not hesitate to medicate or take child to a medical facility.

PHYSICIAN/NP/APN SIGNATURE: ______________________________ DATE: ______________

PHYSICIAN STAMP:

PARENT/GUARDIAN SIGNATURE: ______________________________

[COMPLETE OTHER SIDE]

PART 2: TO BE COMPLETED BY PARENT/CAREGIVER (and STUDENT WHO WILL SELF-ADMINISTER)

EMERGENCY CONTACTS:

Name: ______________________ #1 Phone: __________________ #2 Phone: __________________

Name: ______________________ #1 Phone: __________________ #2 Phone: __________________

Name: ______________________ #1 Phone: __________________ #2 Phone: __________________

A. PARENT/CAREGIVER PERMISSION FOR SCHOOL NURSE TO ADMINISTER MEDICATION

I give my permission for the school nurse to administer the medication described on the reverse side. I will notify the nurse immediately if this medication is no longer required.

I disclaim all liability of Abundant Life Academy as it concerns the use of this medication.

I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by Abundant Life Academy.

______________________________ ____________________

Parent/Caregiver Signature Date

B. PROTOCOL FOR THE SELF-ADMINISTRATION OF EPI-PEN AND/OR ANTIHISTAMINE

- To be completed by the **PARENT/CAREGIVER**:

I give permission for my child to self-administer the medication as described on the reverse side.

I understand and agree that Abundant Life Academy shall incur no liability as a result of any injury arising from the self-administration of the medication by the pupil and that I shall indemnify and hold harmless Abundant Life Academy, its employees, or agents against any claims arising out of the self-administration of medication by the pupil.

I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by Abundant Life Academy.

______________________________ ____________________

Parent/Caregiver Signature Date

- To be completed by the **STUDENT** who will self-administer the medication:

I understand that I will use this medication as directed by my physician. I will be responsible and discreet using the medication as described on the reverse side and should have this medication readily accessible. I have been instructed how to self-administer the medication and understand the side effects of improper use.

I understand that if I do not abide by these regulations, I may forfeit my right to carry and self-administer the medication.

______________________________ ____________________

Student Signature Date