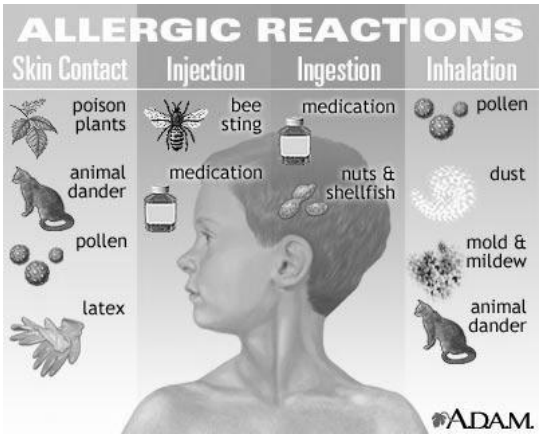
GREAT HEARTS ACADEMY – ALLERGY ACTION PLAN for the 2020/2021 SCHOOL YEAR



FIRST NAME: _____

LAST NAME: _____ DOB: _____

PARENT/GUARDIAN: _____

BEST CONTACT PHONE NUMBER: _____

PHYSICIAN NAME: _____

PHYSICIAN PHONE NUMBER: _____

TEACHER: _____ ROOM # _____

ALLERGIES: _____

TYPE OF REACTION: _____Anaphylaxis _____Nausea/Vomiting _____Rash

Other reaction: _____

Allergic reaction may occur by: _____Ingestion _____Inhalation _____Touch or Other: _____

Is the student asthmatic? _____yes _____no

My student will be eating food provided by local vendors for lunch _____yes _____no

☐ My child may exhibit **MILD** symptoms with exposure to allergen _____

Treatment of **MILD** symptoms include:

1. Note time and occurrence of symptoms and stay with student
2. Watch closely for any sign of a serious reaction
3. Call parent/guardian listed above or communicate in writing of event
4. Give the following Medication: _____ Given to nurse _____yes _____date
   Dose: _____
   May repeat: _____
   Other instructions: _____
5. Call 911 or give emergency medications if symptoms worsen

☐ My child may exhibit **SEVERE** symptoms with exposure to allergen _____

(Exhibiting <u>any</u> or all of the following symptoms is considered to be a severe allergic reaction: widespread hives and flushing, widespread tissue swelling, swelling of the tongue, throat itching or a sense of tightness in the throat, hoarseness and/or hacking cough, vomiting, nausea, cramps, diarrhea, repetitive coughing, wheezing, trouble breathing, rapid heart rate, lightheadedness, dizziness, loss of consciousness) Treatment of **SEVERE** symptoms include:

1. Note time and occurrence of symptoms and stay with student
2. Call 9-1-1 and inform them of a severe allergic reaction
3. Administer according to package instructions(circle) EpiPen 0.3 mg intramuscularly Given to nurse ____yes
   EpiPen Jr. 0.15 mg intramuscularly
   TwinJect 0.3 mg intramuscularly
   Twinject 0.15 mg intramuscularly
4. Call parent/guardian listed above, continue monitoring student for return of severe symptoms
5. Give injection device used, packaging, and student information to emergency responders
6. Give the following ANTIHISTAMINE: _____ Given to nurse _____yes _____date
   Dose: _____
   May repeat: _____
   Other instructions: _____

I understand that school staff MUST be informed of my child's health concerns in order to provide safe and appropriate care. I will update the school nurse office as my child's health conditions/treatments change throughout the year.

Parent/Guardian signature: _____ Date: _____

Food Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: _____

D.O.B.: _____

Allergy To: _____

Weight:_____lbs. Asthma: O Yes (higher risk for a severe reaction) D No

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive 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, diarrhea, crampy pain

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   - -Antihistamine
   - -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

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 above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose_____

Antihistamine (brand and dose): _____

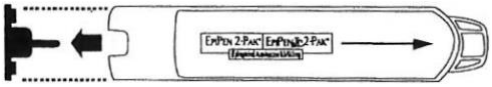
Other (e.g., inhaler-bronchodilator if asthmatic): _____

_____ _____ _____ _____

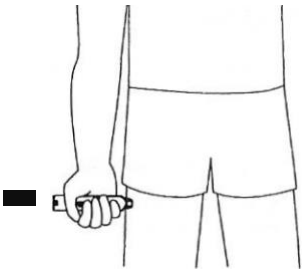
Parent/Guardian Signature Date Physician/Healthcare Provider Signature Date

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions

Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip.

Contacts:

Call to 911: _____

Doctor:_____ Phone:_____

Parent/Guardian: _____ Phone: _____

Name/Relationship: _____ Phone: _____