Fairview Park City School District

21620 Mastick Rd., Fairview Park, OH 44126 P: (440) 331-5500 • F: (440) 356-3545
Keith Ahearn, Superintendent • Rob Showalter, Treasurer
MS/HS Clinic Fax: (440) 356-3529 • **Gilles-Sweet Clinic Fax:** (440) 356-3701 • **EEC Clinic Fax:** (440) 356-3544

psi | University Hospitals Rainbow Babies & Children's

ALLERGY ACTION PLAN

USE 1 FORM PER CHILD FOR EACH ALLERGEN

Student Photo

Student_____School_____.
DOB_____Age_____Weight_____Grade/Rm_____
Allergy to _____
START DATE:_____ **END DATE:**_____

Student has asthma.	❑ Yes	❑ No (If yes, higher chance of severe reaction)
Student has had anaphylaxis.	❑ Yes	❑ No
Student may carry epinephrine.	❑ Yes	❑ No (if yes, complete next page)
Student may give him/herself medicine.	❑ Yes	❑ No (If student refuses/is unable to self-treat, an adult must give medicine.)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for
If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- ☐ Shortness of breath, wheezing, or coughing
- ☐ Skin color is pale or has a bluish color
- ☐ Weak pulse
- ☐ Fainting or dizziness
- ☐ Tight or hoarse throat
- ☐ Trouble breathing or swallowing
- ☐ Swelling of lips or tongue that bother breathing
- ☐ Vomiting or diarrhea (if severe or combined with other symptoms)
- ☐ Many hives or redness over body
- ☐ Feeling of "doom," confusion, altered consciousness, or agitation
- ❑ ***SPECIAL SITUATION: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____. Even if child has MILD symptoms after a sting or eating these foods, give epinephrine.***

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - ☐ Ask for ambulance with epinephrine.
   - ☐ Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - ☐ Call parents and child's doctor.
   - ☐ Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - ☐ Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - ☐ Antihistamine
   - ☐ Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for
If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- ☐ Itchy nose, sneezing, itchy mouth
- ☐ A few hives
- ☐ Mild stomach nausea or discomfort

Monitor child
What to do
Stay with child and:

- ☐ Watch child closely.
- ☐ Give antihistamine (if prescribed).
- ☐ Call parents and child's doctor.
- ☐ If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis")

Medication/Doses
Epinephrine autoinjector, intramuscular (list type):_____Dose:❑ 0.15 mg ❑ 0.30 mg
Antihistamine, by mouth (type and dose): _____
Other (for example, inhaler/bronchodilator if student has asthma):_____

Parent/Guardian Authorization Signature	**Date**	**Physician/HCP Authorization Signature**	**Date**

Emergency Contacts/Relationship — Telephone number

1._____ _____
2._____ _____
3._____ _____

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******(To be completed ONLY if student will be carrying an Epinephrine Autoinjector)******

AUTHORIZATION FOR STUDENT POSSESSION AND USE OF AN EPINEPHRINE AUTOINJECTOR

(In accordance with ORC 3313.718/8313.141)

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

Parent /Guardian signature	Date
Parent /Guardian name	Parent /Guardian emergency telephone number ( )

This section must be completed and signed by the medication prescriber.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Circumstances for use of the epinephrine autoinjector
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the prescriber)
To a student for which it is **not** prescribed who receives a dose

Special instructions

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ( )

Developed in collaboration with the Ohio Association of School Nurses.

HEA 4222 3/07