ALLERGY ACTION PLAN
USE 1 FORM PER CHILD FOR EACH ALLERGEN

Student ____________________________ School ____________________________
DOB ____________________________ Teacher/Grade ____________________________

Allergy to ____________________________

Asthmatic? □ Yes* □ No  *Higher risk for severe reaction

STEP 1 - TREATMENT
SEND STUDENT TO HEALTH OFFICE ACCOMPANIED BY RESPONSIBLE PERSON.
The severity of symptoms can quickly change. †Potentially life threatening.

Symptoms
♦ If a student has been exposed to/ingested an allergen but has NO symptoms:
♦ Mouth Itching, tingling, or swelling of lips, tongue, mouth:
♦ Skin Hives, itchy rash, swelling of the face or extremities:
♦ Gut Nausea, abdominal cramp, vomiting, diarrhea:
♦ Throat† Tightening of throat, hoarseness, hacking cough:
♦ Lung† Shortness of breath, repetitive coughing, wheezing:
♦ Heart† Tready pulse, low blood pressure, fainting, pale, blueness:
♦ Other† __________________________________________________________:
♦ If reaction is progressing, (several of the above areas affected), give:

MEDICATION: ________________________________ START DATE ________________ END DATE ________________

Epinephrine: Inject intramuscularly.
☐ Epinephrine Autoinjector 0.3mg
☐ Epinephrine Autoinjector 0.15mg

Antihistamine: Give ____________________________________________________________

Other: Give ________________________________________________________________

medication/dose/route

Parent/Guardian Signature ____________________________ Date ______________________
Prescriber Name ____________________________ Phone ____________________________
Prescriber Signature ____________________________ Date ______________________

I received a copy of the Section 504 Procedural Safeguards for the current school year. ________________ Parent Signature

STEP 2 - EMERGENCY CALLS

PARAMEDICS (911) MUST BE CALLED IF EPIPEN OR AUVI-Q IS GIVEN. EPIPEN OR AUVI-Q ONLY LAST 15-20 MINUTES.

Call 911. State that an anaphylactic reaction has been treated, type of treatment given (i.e., EpiPen or Auvi-Q) and that additional epinephrine may be needed. Always send empty autoinjector to ER with student. Contact Parent/Guardian.

EVEN IF PARENT/GUARDIAN IS UNAVAILABLE, DO NOT HESITATE TO MEDIATE CHILD & CALL 911

EMERGENCY CONTACTS

1. ____________________________ Relationship ____________________________ Telephone number ____________________________
2. ____________________________ Relationship ____________________________ Telephone number ____________________________

*** Form on Page 2 to be completed ONLY if student will be carrying an Epinephrine Autoinjector ***

Rev. 4/2016 Solon City School District
AUTHORIZATION FOR STUDENT POSSESSION AND USE OF AN EPINEPHRINE AUTOINJECTOR
(In accordance with ORC 3313.718/8313.141)

<table>
<thead>
<tr>
<th>Student name</th>
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<tbody>
<tr>
<td>Student address</td>
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</tbody>
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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.

<table>
<thead>
<tr>
<th>Parent/Guardian signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian name</td>
<td>Parent/Guardian emergency telephone number</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name and dosage of medication</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Date medication administration begins</th>
<th>Date medication administration ends (if known)</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Prescriber signature</th>
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</thead>
<tbody>
<tr>
<td>Prescriber name</td>
<td>Prescriber emergency telephone number</td>
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Developed in collaboration with the Ohio Association of School Nurses.

HEA 4222 3/07

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