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University Hospitals Rainbow Babies & Children's

ALLERGY ACTION PLAN

(Use 1 form per child for each allergen)

Student_____School_____ Student Photo

DOB_____Age_____Weight_____Grade/Rm_____

Allergy_____

START DATE_____ END DATE_____

- ☐ Student has Asthma (higher chance of severe reaction)
- ☐ Student has history of Anaphylaxis
- ☐ Student may self-carry Epinephrine (if yes, complete self-carry authorization form)
- ☐ Student may self-administer medication (If student refuses/is unable to treat, an adult must give medication)

RECOGNITION AND TREATMENT OF SYMPTOMS

Medication

- ☐ If student has been exposed to/ingested an allergen but has **NO** symptoms — ☐ Epinephrine ☐ Antihistamine
- ☐ **Mouth**: Itching, tingling, or swelling of lips, tongue, mouth — ☐ Epinephrine ☐ Antihistamine
- ☐ **Skin**: Hives, itchy rash, redness, swelling of face or extremities. — ☐ Epinephrine ☐ Antihistamine
- ☐ **Gut**: Nausea, abdominal cramps, vomiting, diarrhea — ☐ Epinephrine ☐ Antihistamine
- ☐ **Throat**: Tightening of throat, hoarseness, hacking cough — ☐ Epinephrine ☐ Antihistamine
- ☐ **Lung**: Shortness of breath, wheezing, repetitive coughing — ☐ Epinephrine ☐ Antihistamine
- ☐ **Heart**: Thready pulse, low blood pressure, fainting, pale, blueness — ☐ Epinephrine ☐ Antihistamine
- ☐ **Other**: _____ — ☐ Epinephrine ☐ Antihistamine
- ☐ **If reaction is progressing (several of the above areas affected) Give**: — ☐ Epinephrine ☐ Antihistamine

ADMINISTER MEDICATION

EPINEPHRINE: (Inject Epi, call 911, request rescue squad with epinephrine)

- ☐ **EpiPen (0.3mg)**
- ☐ **Auvi-Q (0.3mg)**
- ☐ **Neffy (2mg)**
- ☐ **Other (0.3mg)** _____
- ☐ **EpiPen Jr (0.15mg)**
- ☐ **Auvi-Q (0.15mg)**
- ☐ **Neffy (1mg)**
- ☐ **Other (0.15mg)** _____

ANTIHISTAMINE: Give _____

OTHER: (E.G., Inhaler/Bronchodilator) _____

***IMPORTANT: During Anaphylaxis, epinephrine is indicated, and asthma inhalers/bronchodilators are unreliable.**

EMERGENCY CONTACTS/RELATIONSHIP — TELEPHONE NUMBER

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

Parent/Guardian Signature **Date** **Physician's Signature** **Date**

******(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.

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