Fairview Park City School District
21620 Mastick Rd., Fairview Park, OH 44126 / P: (440) 331-5500
High School Fax: (440) 356-3529/ **Middle School Fax:** (440) 356-3545/ **Elementary Fax:** (440) 356-3701/ **EEC Fax:**
Superintendent: Dr. William W. Wagner · Treasurer: Kimberly Sperling

ALLERGY ACTION PLAN

Student: _____

DOB: _____ Grade: _____

Allergy to: _____

Asthmatic? **[ ] NO** **[ ] YES**- Higher risk for severe reaction

STEP 1 – TREATMENT

SEND STUDENT TO HEALTH OFFICE ACCOMPANIED BY RESPONSIBLE PERSON.

Symptoms	**Give checked Medication**
The severity of symptoms can quickly change. †Potentially life threatening.	*To be determined by physician authorizing treatment*
* If a 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, swelling of the 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, repetitive coughing, wheezing:	[ ]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

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MEDICATION:

START DATE _____ END DATE _____

Epinephrine: Inject intramuscularly. Select correct epinephrine dose below:

[ ] Epinephrine Autoinjector **0.3mg**

[ ] Epinephrine Autoinjector **0.15mg**

Antihistamine: Give _____
antihistamine/dose/route

Other: Give _____
medication/dose/route

****Important**; Asthma inhalers and/or antihistamines cannot be depended upon to replace epinephrine in anaphylaxis*

Parent/Guardian Signature: _____ Date: _____

Prescriber Name: _____ Phone: _____

Prescriber Signature: _____ Date: _____

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 MEDICATE CHILD & CALL 911!

EMERGENCY CONTACTS

Name:_____ Relationship: _____ Telephone:_____

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Page 3 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)

***To be completed ONLY if student will be carrying/administering an Epinephrine Autoinjector**

Student name: _____ DOB: _____ Grade:_____

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**):**

_____

Possible severe adverse reactions 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: ( )