



## 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

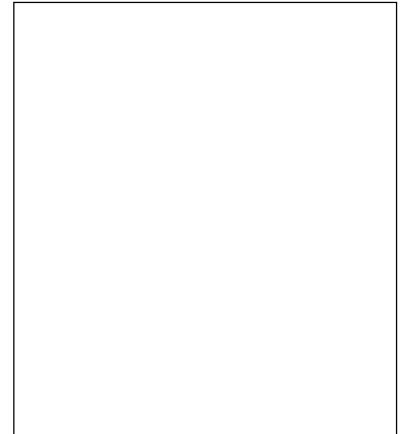
# ALLERGY ACTION PLAN

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

*The severity of symptoms can quickly change. †Potentially life threatening.*

- \* 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 cramps, vomiting, diarrhea:
- \* Throat†: Tightening of throat, hoarseness, hacking cough:
- \* Lung†: Shortness of breath, repetitive coughing, wheezing:
- \* Heart†: Thready pulse, low blood pressure, fainting, pale, blueness:
- \* Other
- \* If reaction is progressing, (several of the above areas affected), give:

### Give checked Medication

*To be determined by physician authorizing treatment*

- Epinephrine  Antihistamine
- 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: (        )