EDMOND PUBLIC SCHOOLS

Allergy Medical Management and Emergency Action Plan

Name ___________________________________ DOB ___________ School Year __________

Teacher ___________________________________ Grade _____________

ALLERGY TO ____

Asthma Yes* ☐ No ☐ *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms	**Give Checked Medication**	
• If a food allergen has been ingested, but 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
• Gastrointestinal – 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 – Weak pulse, low blood pressure, fainting, pale, blueness:	☐ Epinephrine	☐ Antihistamine
• Other ________________________________	☐ Epinephrine	☐ Antihistamine

DOSAGE

Epinephrine: Inject intramuscularly

___ Epi-pen 0.3mg ___ Epi-pen JR 0.15 mg ___ Twinjet 0.3 mg ___ Twinjet 0.15 mg ___ Auvi-Q 0.3 mg ___ Auvi-Q 0.15 mg

Antihistamine: give ____

(medication/dose/route)

Other: give____

(medication/dose/route)

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Parent ___________________________________ Phone Number _____________________
3. Emergency Contacts:

Name/Relationship	**Phone Number (s)**	
___________________________________	1.________________	2.________________
___________________________________	1. ________________	2. ________________

I give permission to the school nurse and other staff members of ________________________ School to perform and carry out the emergency care tasks as outlined by _________________________'s Allergy Medical Management Plan. I also consent to the release of the information contained in this Allergy Medical Management Plan to all school staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Parent/Guardian ____ Date ____________________

Acknowledged and received by:

School Nurse ____ Date ____________________

Revised 10//2013