Our Lady of Mt. Carmel School
14596 Oak Ridge Rd Carmel, IN 46032
317-846-1118

Place Child's Picture Here

ALLERGY ACTION PLAN

Student's Name: ______________________________ DOB: ______________

School: ________________________ Teacher/Grade: _____________________

Weight: _____ lbs. Asthma: [ ] No [ ] **Yes (higher risk for a severe reaction, complete asthma action plan)**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

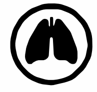
What is the student allergic to? (please check) [ ] Bee/Insect Stings [ ] Latex

[ ] Eggs [ ] Soy [ ] Wheat [ ] Dairy [ ] Shellfish

[ ] Tree-Nuts (almonds, pecans, walnuts, etc.) [ ] Peanuts [ ] Other Food(s): ____________________

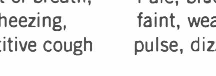
FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy



THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - Antihistamine
  - Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: ______________________

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: ________________

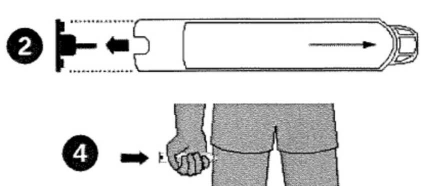
Antihistamine Dose: __________ mg __________

Other (e.g., inhaler-bronchodilator if wheezing): __________

____

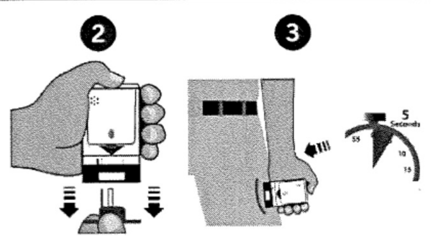
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



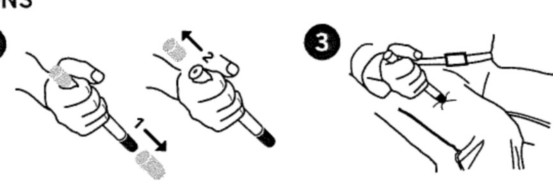
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



Additional Allergy Comments/Instructions:

IF YOU INJECT EPINEPHRINE, CALL 911 AND PARENTS.

Parent/Guardian: ______________________________ Phone: ________________

Emergency Cóntact: ______________________________ Phone: ________________

[ ] **Yes** [ ]**No** This student has been trained in the use of the medication(s) above and he/she may carry and self-administer if needed, for life threatening allergic reaction.

______________________ ______________________ __________

ALLERGY CARE PROVIDER SIGNATURE **PLEASE PRINT PROVIDER NAME** **DATE**

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

______________________ __________

PARENT SIGNATURE **DATE**