Riverside Township School District
112 E. Washington Street
Riverside, New Jersey 08075

ALLERGY ACTION PLAN

Student's Name:_____ **D.O.B.**_____ **Grade:**_____

ALLERGY TO:_____

To be completed by Physician

Has had an anaphylactic reaction in the past ____YES _____NO
If yes, when and what where the symptoms_____
Student Asthmatic _____YES* ____NO *High risk for severe reaction

STEP 1: TREATMENT

Symptoms:

Give Checked Medicaton**
****To be determined by doctor**

• If child exposed to allergen, 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
• 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

The severity of symptoms can quickly change = Potentially life-threatening.

DOSAGE

Epinephrine: Inject IM into outer thigh (circle one) EpiPen 0.3mg EpiPen Jr. 0.15mg TwinJect 0.3mg Twinject 0.15mg

Antihistamine: give_____
Medication /Dose /Route

Other: give _____

___This student is capable and has been instructed in the proper method of self-administering epinephrine using an auto-injector and may self medicate.

___This student may not self medicate.

Physician Name:_____ Signature:_____ Date:_____

STEP 2: EMERGENCY CONTACTS

To be completed by parent

1. **Call 911** State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Doctor:_____ Phone Number:_____
3. Parent:_____ Phone Number(s):_____
4. Emergency Contacts

Name/Relationship and Phone Number(S)

a._____ 1.) _____ 2.) _____

b._____ 1.) _____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY.

Parent Name:_____ Signature:_____ Date:_____

RIVERSIDE TOWNSHIP PUBLIC SCHOOLS
112 E. WASHINGTON STREET
RIVERSIDE NEW JERSEY 08075
Phone: 856-461-1255 Middle School Fax: 856-461-0182 High School Fax: 856-461-7277

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATON FOR EPINEPHRINE VIA AUTO-INJECTOR FOR ANAPHYLAXIS

SCHOOL YEAR_____

STUDENT'S NAME:_____ DOB:_____ GR._____

Completed by Physician

Diagnosis/Allergy(s):_____
Medication:_____
Dose and Frequency:_____
Indication for use:_____
Side Effects:_____
I verify that the above named student has been adequately trained in the use of his/her medication, therefore, is capable of carrying and self-administering the above named medication for anaphylaxis provided that the pupil does not endanger him/herself or other persons through misuse.

Doctor's Name:_____ Signature:_____ Date:_____

Physician's Number:_____ Physician's Address:_____

Completed by Parent/Guardian
Agreement for Self-Administration of Medication

I request that my child be permitted to carry and self –administer their medication for anaphylaxis as listed above. I verify that I have observed my child technique on self-administering his/her medication and is competent to do so. In signing this form I acknowledge that the Riverside Township School District shall incur no liability as a result of injury arising from the self-administration of medication for anaphylaxis. I shall indemnify and hold harmless the Riverside Township School District and its employees, including school nurse, or any other officer or agents of the board of education against any claims, arising out of the self-administration of medication by my child.

Parents the following guidelines will be used for the self –administration of epinephrine via auto-injector:

1. This request for self-administration of epinephrine for anaphylaxis must be done annually for each school year.
2. Parents should instruct their child to keep the medication for anaphylaxis with them at all times and labeled with name and allergy. Parent is to supply ALL medications.
3. It is recommended that "back up" medication be kept in the Nurse's Office.
4. Parents are to instruct their child that whenever they self-administer their medication they are to inform teacher, coach, or other individual in charge and 911 will be called. Also nurse needs to be informed.

PARENT/GUARDIAN NAME:_____ SIGNATURE:_____
PARENT/GUARDIAN NAME:_____ SIGNATURE:_____
DATE OF AGREEMENT:_____

OFFICE USE ONLY:
Building Principal:_____ School:_____

INDIVIDUAL HEALTH CARE PLAN
ANAPHYLAXIS

NAME:_____ **DOB:**_____

MEDICATION:_____

DATE:_____ **GRADE:**_____

NURSING DIAGNOSIS: 1. Ineffective breathing Pattern and Decreased Cardiac Output related to an excessive hypersensitivity to an allergen.
2. Knowledge Deficit related to allergens and prevention through risk reduction.

GOALS: The student will:

- maintain a patent airway and adequate cardiac output.

The student and family will:

- avoid known allergen(s)_____
- learn/demonstrate proper use of emergency epi-pen

INTERVENTIONS:

1. Maintain an adequate airway, administer oxygen and assist ventilation if needed.
2. Administer prescribed medication as ordered:_____
3. Assess level of consciousness, check airway, breathing and circulation.
4. Check vital signs.
5. Call 911.
6. Contact parent(s)/guardians.
7. Educate student, staff, and parent(s)/guardian about anaphylaxis,(signs, symptoms and treatment) and allergen(s).
8. Student to carry epi-pen on field trips.

EVALUATION: The student maintains a patent airway and cardiac output.
The student and family avoid known allergen(s).

COMMENTS:_____

SCHOOL NURSE_____ **PARENT/GUARDIAN**_____

Date Date