Abundant Life Academy
Life-Threatening Allergy Action Plan

PART 1: TO BE COMPLETED BY PHYSICIAN

Student Name: _____ DOB: _____ Grade/Teacher: _____

ALLERGY TO: _____

DIAGNOSIS: _____

STEP 1: TREATMENT

SYMPTOMS:	GIVE CHECKED MEDICATION:	
• If a food allergen has been ingested, but there are NO symptoms	_____ Epinephrine	_____ Antihistamine
• Mouth: itching, tingling, or swelling of lips, tongue, and mouth	_____ Epinephrine	_____ Antihistamine
• Skin: hives, itchy rash, swelling of face or extremities	_____ Epinephrine	_____ Antihistamine
• Gut: nausea, abdominal cramps, vomiting, and diarrhea	_____ Epinephrine	_____ Antihistamine
• Throat: tightening of throat, hoarseness, hacking cough	_____ Epinephrine	_____ Antihistamine
• Lungs: shortness of breath, repetitive coughing, wheezing	_____ Epinephrine	_____ Antihistamine
• Heart: thready pulse, low blood pressure, fainting, pale, blue	_____ Epinephrine	_____ Antihistamine
• Other: _____		
• If reaction is progressing (several of the above areas affected), give [The severity of symptoms can quickly change and be potentially life-threatening.]	_____ Epinephrine	_____ Antihistamine

IF THERE IS INADEQUATE RESPONSE TO THE FIRST DOSE OF EPI INJECTION WITHIN 10 MINUTES, ADMINISTER A SECOND DOSE.

MEDICATION:

Epinephrine: Inject intramuscularly (CHECK ONE) **_____ Epi-Pen 0.3 mg _____ Epi-Pen Jr. 0.15 mg _____ Other**

Antihistamine: Give _____
(Medication/Dosage/Route)

CHECK ALL THAT APPLY:

_____ Student has been trained in Epi-Pen administration and is both capable and responsible to self-administer Epinephrine. (see reverse)

_____ Student has been instructed in symptom recognition, is capable of, and may self-administer antihistamine. (see reverse)

_____ The antihistamine may be omitted from the above plan on a field trip in the absence of an authorized licensed staff member and when the student is not capable of administering it. (The parent has the option of accompanying child and administering an antihistamine, if necessary, on the field trip.)

In the absence of the school nurse, the order for the antihistamine should be disregarded and Epinephrine should be administered by the designated substitute.

STEP 2: EMERGENCY CALLS

1. Call 911 to request paramedics: State that an allergic reaction has been treated with epinephrine, and that additional epinephrine may be needed.
2. Call Doctor _____ at _____.
3. Call Emergency Contacts listed on the reverse side.

If a parent or caregiver cannot be reached, do not hesitate to medicate or take child to a medical facility.

PHYSICIAN/NP/APN SIGNATURE: _____ DATE: _____

PHYSICIAN STAMP:

PARENT/GUARDIAN SIGNATURE: _____

[COMPLETE OTHER SIDE]

PART 2: TO BE COMPLETED BY PARENT/CAREGIVER (and STUDENT WHO WILL SELF-ADMINISTER)

EMERGENCY CONTACTS:

Name: _____ #1 Phone: _____ #2 Phone: _____

Name: _____ #1 Phone: _____ #2 Phone: _____

Name: _____ #1 Phone: _____ #2 Phone: _____

A. PARENT/CAREGIVER PERMISSION FOR SCHOOL NURSE TO ADMINISTER MEDICATION

I give my permission for the school nurse to administer the medication described on the reverse side. I will notify the nurse immediately if this medication is no longer required.

I disclaim all liability of Abundant Life Academy as it concerns the use of this medication.

I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by Abundant Life Academy.

_____ _____
Parent/Caregiver Signature Date

B. PROTOCOL FOR THE SELF-ADMINISTRATION OF EPI-PEN AND/OR ANTIHISTAMINE

- To be completed by the **PARENT/CAREGIVER**:

I give permission for my child to self-administer the medication as described on the reverse side.

I understand and agree that Abundant Life Academy shall incur no liability as a result of any injury arising from the self-administration of the medication by the pupil and that I shall indemnify and hold harmless Abundant Life Academy, its employees, or agents against any claims arising out of the self-administration of medication by the pupil.

I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by Abundant Life Academy.

_____ _____
Parent/Caregiver Signature Date

- To be completed by the **STUDENT** who will self-administer the medication:

I understand that I will use this medication as directed by my physician. I will be responsible and discreet using the medication as described on the reverse side and should have this medication readily accessible. I have been instructed how to self-administer the medication and understand the side effects of improper use.

I understand that if I do not abide by these regulations, I may forfeit my right to carry and self-administer the medication.

_____ _____
Student Signature Date