PROVIDENT CHARTER SCHOOL- HEALTH SERVICES
ANAPHYLACTIC ALLERGY ACTION PLAN

STUDENT NAME:	DOB:	GRADE:	ENTER SCHOOL YEAR:

ANAPHYLACTIC ALLERGY TO: _____

☐ Yes	☐ No	The student is responsible for carrying the EpiPen with them during the school day.
☐ Yes	☐ No	The EpiPen will be kept with the nurse or office for immediate retrieval.

Medically necessary classroom or lunchroom accommodations? Yes or No. If yes, please explain. _____

STEP 1: TREATMENT

If a food allergen has been ingested, but no symptoms	☐ EpiPen	☐ Benadryl
If stung by an insect, with or without symptoms	☐ EpiPen	☐ Benadryl
Skin- Hives, itchy rash, swelling of lips or tongue	☐ EpiPen	☐ Benadryl
Mouth- itching, tingling, or swelling of lips or tongue	☐ EpiPen	☐ Benadryl
Gut- Nausea, belly cramps, sudden vomiting or diarrhea	☐ EpiPen	
Throat- Tightening of throat, hoarseness, hacking cough	☐ EpiPen	
Lung- shortness of breath, repetitive coughing, wheezing	☐ EpiPen	
Heart- Thready pulse, fainting, pale, blueness, low BP	☐ EpiPen	
Other:	☐ EpiPen	

DOSAGE **This emergency medication should be administered IMMEDIATELY BY THE NURSE, STUDENT, OR DESIGNATED SCHOOL STAFF.

EPINEPHRINE: Inject intramuscularly (check one) EpiPen _____ OR EpiPen Jr. _____

Benadryl: give _____ tsp or _____ tab (s) by mouth if student can swallow

Other: (Albuterol inhaler etc.) _____

STEP 2: CALL EMS if a severe allergic reaction occurs or EpiPen is used.

1. CALL 911, state that an allergic reaction has been treated, and additional support is needed. 2. Emergency Contacts: Call the parent/guardian to notify them of the incident.

Name & Relationship: _____Phone: _____

Name & Relationship: _____ Phone: _____I

I agree with the above plan and agree that school health personnel and my child's physician or staff may discuss this plan if there are questions.

X _____ X _____ X _____
SIGNATURE-PARENT/GUARDIAN/LEGAL REP. PRINT NAME DATE

X _____ X _____ X _____
PHYSICIAN SIGNATURE PHYSICIAN PRINT NAME PHONE

X _____ X _____ X _____
DATE PHONE FAX