JACKSON R-2 SCHOOL DISTRICT
ALLERGY ACTION PLAN

Name: _____ **D.O.B.:** ____/____/____
Allergy to: _____ **Weight:** ____lbs. **Asthma:** ___ Yes (higher risk for a severe reaction) __ No
Extremely reactive to the following: _____
THEREFORE:

_____ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* to have come in contact.

_____ If checked, give epinephrine immediately if the allergen *definitely* came in contact, even if no symptoms are noted

Any SEVERE SYMPTOMS after suspected or known ingestion: **One or more** of the following: LUNG: short of breath, wheeze, repetitive cough HEART: pale, blue, faint, weak pulse, dizzy, confused THROAT: tight, hoarse, trouble breathing/swallowing MOUTH: obstructive swelling(tongue and/or lips) SKIN: Many hives over body Or **combination** of symptoms from different body areas: SKIN: Hives, itchy rashes, swelling (e.g. eyes, lips) GUT: Vomiting, cramp pain	**1. INJECT EPINEPHRINE IMMEDIATELY** **2.** Call 911 **3.** Begin monitoring (see box below) **4.** Give additional medications:* -Antihistamine -Inhaler (bronchodilator) if asthma *Antihistamine & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.
MILD SYMPTOMS ONLY: MOUTH: Itchy mouth SKIN: A few hives around mouth/face, mild itch GUT: Mild nausea/discomfor	**1. GIVE ANTIHISTAMINE** **2.** Stay with student; alert healthcare professionals and parent **3.** If symptoms progress (see above), USE EPINEPHRINE **4.** Begin monitoring

Medications/Doses
Epinephrine (brand and dose): _____ Antihistamine (brand and dose): _____
Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring
Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.

_____ _____ _____ _____
Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

CONTACTS
Call 911 (Rescue squad: ( )_____-_____) Doctor: _____ Phone:_____-_____
Parent/Guardian:_____ Phone:_____-_____
Other Emergency Contacts
Name/Relationship: _____ Phone:_____-_____
Name/Relationship: _____ Phone:_____-_____

JACKSON R-2 SCHOOL DISTRICT
ALLERGY NEEDS ASSESSMENT

Student name _____ Date of birth _____

Please, complete this form and return it to the school nurse. Thank you, for helping us keep your child safe and healthy at school.

Please list what your child is allergic to (include all foods, insects, medications, environmental, and latex):

_____
_____
_____
_____

1. **What kind of reaction has your child had to the above listed allergen(s) in the past?**
   Hives Rash Itching Vomiting Swelling Wheezing Hard to breathe
   Other? _____

2. **When was the last time your child had an allergic reaction?** _____

3. **Did you use an EpiPen in this reaction?** Yes No

4. **Have you ever used an EpiPen or any additional medications at school to keep them safe with allergies?** Yes No
   If yes, when?_____

5. **Does your child require an EpiPen or any additional medication at school to keep them safe with allergies?** Yes No
   (If yes, please complete and return the medication authorization form.)

6. **When was your child's last doctor visit for the above listed allergy(ies) and what suggestions did he/she give if a reaction occurs?**
   _____
   _____

7. **Did you receive a Food Allergy Action Plan (FAAP) from your child's doctor?** Yes No

8. **Does your child require special diet restrictions from the school cafeteria?** Yes No

_____ _____
PARENT/GUARDIAN SIGNATURE DATE