Rock Brook School

Emergency Allergy Action Plan

Affix Student's Picture Here

School Year: _____

Student's Name: _____ DOB: ____/____/____

Teacher: _____ Class: _____ Age: _____

Physician/Health Care Provider to complete & sign:

List all known life threatening allergens: _____

Asthma: ☐- Yes (increased risk of severe reaction) ☐- No

The following statements apply ONLY to food allergens:
Extremely Reactive to the following food(s): _____
Therefore:
☐-If checked, give epinephrine immediately for any symptoms if the allergen was likely eaten.
☐-If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

SEVERE SYMPTOMS after suspected or known ingestion or exposure to allergen:

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 swallowing or breathing
- MOUTH: Obstructive swelling (tongue and /or lips)
- SKIN: Many hives over body

Or **combination** of symptoms from different body areas:
- SKIN: Hives, itch rashes, swelling (e.g., eyes, lips)
- GUT: Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911 – Request Ambulance with epinephrine
3. Continually monitor student's condition
4. Administer antihistamines & inhaler/ bronchodilator· if asthma (only RNs may administer) *

*Delegates are not authorized to administer antihistamines or bronchodilators per statute- N.J.S.A. 18A:40-12.6.
·Antihistamines & Inhaler-bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE!**

Medications/Dosage:

Epinephrine (auto-injector dose): _____
Administer a second dose of epinephrine if student's condition does not improve within 10-15 minutes after the first dose is given: ☐-YES ☐-NO

Antihistamine (dose): _____
(*Delegate cannot administer)

Other (e.g., inhaler-bronchodilator if asthmatic): _____
(*Delegate cannot administer)

MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth/throat
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/stomach ache

1. **GIVE ANTIHISTAMINE***
2. Monitor student's condition
3. If symptoms progress (see above). **USE EPINEPHRINE!**

TURN FORM OVER

Capacity for self-administration of epinephrine
Physician/Healthcare Provider should initial applicable statement:

_____ Student **must carry** his/her epinephrine during the school day and is **capable of self-administration**. He/she has received instruction, and demonstrates the proper use of epinephrine using a training device. **If for any reason the student cannot self-administer, the nurse, or delegate will administer the epinephrine.** I understand that a delegate cannot administer antihistamines.

_____ Student **does not have the capacity for self-administration** of epinephrine, but will **carry** this medication to be administered by a nurse or delegate in the event of an emergency. Transportation services will be notified. I understand that a delegate cannot administer antihistamines.

_____ Student **does not have the capacity** for self-administration of epinephrine. An auto-injector of epinephrine will be provided to the nurse's office at the beginning of each school year and a nurse or delegate will administer this medication as needed.

MD Stamp Here

X_____/_____
Physician/Healthcare Provider Signature *Date*

PLEASE NOTE: For students with diagnosed life-threatening allergies, the following bulleted items must be provided & updated each school year for emergencies during school and off-campus events (e.g. field trip, overnight trip, sports.)

- All emergency medications as noted by the student's physician with current expiration date
- If a 2nd dose of epinephrine is authorized by Health Care Provider (see front of form), please provide two auto-injectors.

Please be advised that your child will not be allowed to participate in athletics, field trips, overnight trips or school sponsored events without a completed and current MTSD Allergy Action Plan on file in the health office.

I understand that in the event of an anaphylactic emergency, epinephrine will be administered to my child by a school nurse and/or delegate as indicated in this allergy action plan. My signature below indicates my acknowledgement that the school district and its employees or agents shall have no liability as a result of any injury arising from the administration of epinephrine to my child. I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of epinephrine via a pre-filled auto injector mechanism.

Emergency Contact Information:
Please PRINT LEGIBLY contact names and phone numbers in order of priority

1. *Parent/Guardian Name (PRINT)* *Preferred Phone*
Alternate phone number

2. *Parent/Guardian Name (PRINT)* *Preferred Phone* *Alternate phone*
number

3. *Parent/Guardian Name (PRINT)* *Preferred Phone* *Alternate*
phone number

Parent/Guardian Signature: X_____ Date:_____

School Nurse Signature: X_____ *Date:*_____

Revised 05/16/16