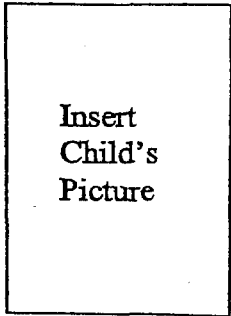


Mitchell Road Christian Academy Allergy Action Plan

Student's Name _____ D.O.B. _____

Teacher _____ Doctor _____



Allergy To: _____ The student cannot eat or handle _____ food(s), or any food containing this ingredient as there is a risk of anaphylaxis (extremely severe allergic reaction).

Asthmatic Yes* No *Higher risk for severe reaction
 Is Student at High Risk for Severe Reaction Yes No

Describe prior history of anaphylaxis (if applicable) _____

STEP 1: TREATMENT

Recognize the symptoms then administer the medication as noted below. Please give if ingestion is known (without symptoms) OR if ingestion is SUSPECTED and symptoms are observed. **The severity of symptoms can quickly change to life threatening. All symptoms can potentially progress into a life-threatening situation.

Symptoms:	Give Checked Medication (To be determined by physician authorizing treatment)	
<input type="checkbox"/> If a food allergen has been ingested, but <i>no symptoms</i>	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Mouth Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Skin Hives, itchy rash, blotchy skin, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Stomach Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Throat** Tightening of throat, hoarseness, hacking cough, itching	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Lung** Shortness of breath, rapid shallow breathing, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Heart** Weak or irregular pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Other**	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

This information shall be shared with individuals who have responsibilities for this student.

DOSAGE (as per physician's orders)

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinject 0.3mg Twinject 0.15 mg

Antihistamine: give _____

Medication Name dose route

Other: give _____

Medication Name dose route

Will the student carry emergency medication on his/her person? Yes No

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: _____). State that a child is having an anaphylactic reaction, has been treated and, additional epinephrine may be needed. Contact parent/guardian or parent/guardian designee if parent/guardian unavailable.

2. Dr. _____ Phone Number _____

3. Parent _____ Phone Number _____

4. Emergency contacts:

Name/Relationship	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/Guardian's Signature _____ Date _____

This individual Health Care Plan for _____ was prepared by

Doctor's Signature _____ (Required) Date _____

Doctor Address _____ Doctor Phone _____

Review Plan Beginning of each school year Parent and/or School Request



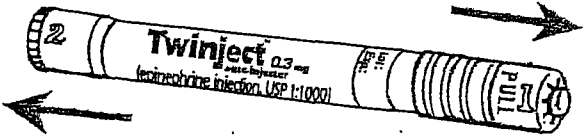



Note: This form is good for one school year only.

PLEASE COMPLETE THIS STATEMENT ONLY IF STUDENT IS TO SELF-ADMINISTER

I have seen this child and agree with all the information provided on this authorization form. This student is allowed to self-administer this medication in the classroom and any area of the school or school grounds, at a school sponsored activity and to and from a school-sponsored activity and understands the implications of doing so. He/she has demonstrated competency in self-monitoring and self-administration of this medication. The parents are aware that they can not hold Mitchell Road Christian Academy responsible for the adverse outcome of this action.

Physician's Signature _____ Initials _____ Date _____

Office Address _____ Office Phone _____

<p>EpiPen® and EpiPen® Jr. Directions</p> <ul style="list-style-type: none"> ▪ Pull off gray activation cap.  <ul style="list-style-type: none"> ▪ Hold black tip near outer thigh (always apply to thigh).  <ul style="list-style-type: none"> ▪ Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds. 	<p>Twinject® 0.3 mg and Twinject® 0.15 mg Directions</p>  <ul style="list-style-type: none"> ▪ Remove caps labeled "1" and "2." ▪ Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove. <p>SECOND DOSE ADMINISTRATION: If symptoms don't improve after 10 minutes, administer second dose:</p> <ul style="list-style-type: none"> ▪ Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base. ▪ Slide yellow collar off plunger. ▪ Put needle into thigh through skin, push plunger down all the way, and remove.   
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Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

