

**Penn Cambria School District
Allergy Action Plan
Emergency Care Plan**

Name: _____ Date of Birth: _____

Grade: _____ Homeroom: _____

Parent/Guardian 1st contact number: _____ 2nd contact number: _____

Allergy to: _____

Asthma: Yes No *(Asthmatics have higher risk for a severe reaction)

- If checked, Epinephrine is to be given immediately for ANY symptoms.
- If checked, Epinephrine is to be given immediately for SEVERE symptoms
- If checked, Antihistamine is to be given first and then watch student for need of Epinephrine.

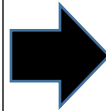
Any **SEVERE SYMPTOMS** after suspected or known ingestion:

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, diarrhea, crampy pain



1. **Inject Epinephrine Immediately**
2. Call 911
3. Begin monitoring (see below)
4. Give additional medications:
 - a. Antihistamine (e.g. Benadryl)
 - b. Inhaler if asthmatic

*Antihistamines & inhalers are not to be depended upon to treat a severe reaction (anaphylaxis).

USE EPINEPHRINE!

1. **GIVE ANTIHISTAMINE (BENADRYL)**
2. Stay with student: alert parent
3. If symptoms progress, USE EPINEPHRINE, follow above
4. Begin monitoring (see below)



MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives, mild itchy
GUT: Mild nausea/discomfort

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g. inhaler): _____

Self-Administration of Epinephrine:

- If checked, this student is capable to safely and properly self-administer this medication and to carry on him/herself. Please complete check list on back.
- If checked, this student is not approved to self-administer this medication.

Healthcare Provider Printed Name: _____ Phone: _____

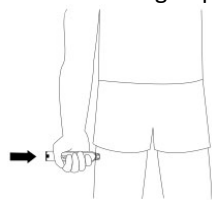
Healthcare Provider Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Monitoring: Stay with student; alert parent. If epinephrine was given; call 911 unless parents indicate otherwise. 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. See back/attached for auto-injection technique.

EpiPen (epinephrine) Auto-Injector Directions

- First, remove the EpiPen from the plastic carrying case
- Pull off the blue safety release cap
- Hold orange tip near outer thigh (always apply to thigh)



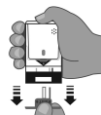
- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.
- Remove EpiPen and massage the area for 10 more seconds.



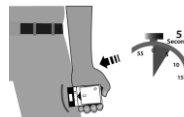
EpiPen; EpiPen 2 Pak; and EpiPen Jr are registered trademarks of Mylan Inc. licensed exclusively to its wholly owned subsidiary, Mylan Specialty LP.

Auvi-Q Directions

- Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
- Pull off **Red** safety guard.



- Place black end against outer thigh, then press firmly and hold for 5 seconds.



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AdrenaClick 0.3mg and AdreanaClick 0.15mg Directions

- Remove **Grey** caps labeled "1" and "2".
- Place **Red** rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

Epinephrine Self-Administration by Student

To self-medicate, the student must be able to:

1. Respond to and visually recognize his/her name.
2. Identify his/her medication.
3. Demonstrate the proper technique for self-administering his/her medication.
4. Demonstrate cooperative attitude in all aspects of self-administration of medication.
5. Report to the nurse after administering medication.

As the parent/guardian, I relieve the School District and its employees of any responsibilities for the benefits or consequences of the above medication when it is physician prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above named medication will result in the immediate confiscation of the medication and loss of privilege to self-administer if the medication policy is violated.

Parent/Guardian Signature: _____ Date: _____

I agree to be solely responsible for my epinephrine auto injector and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I am aware that any abuse of this privilege will result in the confiscation of my medication.

Student's Signature: _____ Date: _____

The above named student has demonstrated the ability to self-administer the physician prescribed anaphylaxis medication, as indicated by the criteria listed above.

Certified School Nurse Signature: _____ Date: _____