Whitehall-Coplay School District
Emergency Action Plan (EAP) ~ Severe Allergic Reaction

Student: ___________________________ Date: ___________________________
Teacher/Classroom: __________________ Bus: ___________________________
Allergy: __________________________

Signs of an Allergic Reaction
* Potentially life threatening
* Lungs: Shortness of breath, repetitive coughing, wheezing
* Heart: Weak pulse, pale, blueness, fainting
* Throat: Tightening, itching, hoarseness, hacking cough
  Mouth: Itching, tingling, swelling of the lips, tongue, and mouth
  Skin: Hives, itchy rash, swelling of face or extremities
  Gut: Nausea, abdominal cramps, vomiting, diarrhea

Other known symptoms: ___________________________________________________

<table>
<thead>
<tr>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give:</td>
</tr>
<tr>
<td>Give:</td>
</tr>
</tbody>
</table>

Emergency Calls
Call 9-911
State that an allergic reaction has been treated, and additional epinephrine may be needed.
1. Parent/guardian: ________________________________________________________
   ________________________________________________________
2. Additional emergency Contacts: __________________________________________
3. Physician: ____________________________________________________________

Parent/Guardian Signature: ___________________________ Date: ___________
Physician Signature: ___________________________ Date: ___________
School Nurse: ___________________________ Date: ___________
School personnel informed: ___________________________ Date: ___________

Care Plans are updated yearly and/or throughout the school year as changes as needed.
### STEP 2: EMERGENCY CALLS

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

<table>
<thead>
<tr>
<th>Adrenaline 0.9 mg</th>
<th>Adrenaline 0.3 mg</th>
<th>MDI 0.15 mg</th>
<th>Timed 0.2 mg</th>
<th>Timed 0.3 mg</th>
</tr>
</thead>
</table>

**DOSEAGE**

<table>
<thead>
<tr>
<th>If reaction is progressing (several of the above steps checked), give:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Epinephrine</strong></td>
</tr>
<tr>
<td><strong>Other</strong></td>
</tr>
<tr>
<td><strong>Heart</strong></td>
</tr>
<tr>
<td><strong>Lung</strong></td>
</tr>
<tr>
<td><strong>Tiroid</strong></td>
</tr>
<tr>
<td><strong>Gut</strong></td>
</tr>
<tr>
<td><strong>Skin</strong></td>
</tr>
<tr>
<td><strong>Mouth</strong></td>
</tr>
</tbody>
</table>

**If a food allergy has been identified, but no symptoms:**

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Give checked medication:
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### STEP 1: TREATMENT

If a food allergy has been identified, but no symptoms:

**Food Allergy Action Plan**

<table>
<thead>
<tr>
<th>Asthma inhaler: Yes</th>
<th>No</th>
</tr>
</thead>
</table>
WHITEHALL-COPLAY SCHOOL DISTRICT
HEALTH SERVICES

FOOD ALLERGY UPDATE

STUDENT NAME: ___________________________  GRADE: _______________________

ALLERGIC TO: ______________________________________________________________

Date of last exposure/reaction: ____________________________

1. When does food allergy occur?
   (If allergic to more than one food, please be specific for each individual food allergen.)
   □ Ingestion  Food name: ________________________
   □ Touch      Food name: ________________________
   □ Inhalation Food name: ________________________

2. My child requires special seating in the cafeteria:
   (If allergic to more than one food, please be specific for each individual food.)
   □ No        Food name: ________________________
   □ Yes       Food name: ________________________

3. Food eaten in school (including lunch and snacks):
   □ Must be provided by a parent.
   □ My child is able to independently choose which foods (s) he eats while in school.

*A conference with the teacher regarding classroom snacks and in class lessons involving food is recommended.

4. For severe allergies, would you like a parent letter to be sent home (WITHOUT NAMING YOUR CHILD) at the beginning of the school year? This letter requests that parents refrain from sending classroom snacks, birthday treats or party items that contain the food allergen into the classroom.
   □ Yes    □ No

PLEASE RETURN THE FOLLOWING BEFORE THE START OF SCHOOL IN SEPTEMBER:

   □ Completed “Food Allergy Action Plan” (signed by parent and physician).

   □ All medications in the original container from the pharmacy.

   □ Medication Authorization forms (signed by both the parent and physician) for each medication needed in school.

Parent/Guardian’s Signature ___________________________ Date _____________
### How to Use an EpiPen

**First,** remove the EpiPen auto-injector from the package.

**Second,** remove the protective cap by pressing it off.

**Third,** hold the EpiPen near the skin and press the plunger down until it clicks. Hold for 10 seconds.

**Fourth,** remove the EpiPen after use. Place the used EpiPen into the supplied puncture resistant container. Do not throw away with regular garbage.

**Fifth,** if symptoms do not improve after 10 minutes, administer a second dose. A second dose can be administered every 5-10 minutes. Please read the instructions on the label for detailed use.

### Administration Directions

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Remove protective cap.</td>
</tr>
<tr>
<td>2.</td>
<td>Hold EpiPen near skin.</td>
</tr>
<tr>
<td>3.</td>
<td>Press plunger down until it clicks.</td>
</tr>
<tr>
<td>4.</td>
<td>Hold for 10 seconds.</td>
</tr>
<tr>
<td>5.</td>
<td>Remove used EpiPen.</td>
</tr>
</tbody>
</table>

**Tips:**
- **Always carry an EpiPen.**
- **Regular check-ups with healthcare provider.**

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**Note:** This information is provided for educational purposes only and should not replace professional medical advice. Always consult with a healthcare provider for specific medical advice.
WHITEHALL-COPLAY SCHOOL DISTRICT

Medication Dispensing Form

To the Physician:

Please complete and sign this form if you request your patient to receive a medication during school hours. By signing this form, you are indicating that the student could not attend school unless this medication was available during the school day.

Medication must be brought in the original bottle and will be kept in the health room. It will be the student’s responsibility to request the medication in the health room.

Student’s name: ___________________ Grade: _____ Teacher: ____________________________

Prescribed medication: ________________________________________________________________

Dosage*, route, and frequency: _______________________________________________________

Time of day to be given: _____________________________________________________________

Reason for medication: ______________________________________________________________

Side effects: _______________________________________________________________________

Is child taking any other medication? Name? _____________________________________________

This authorization is in effect from: ____________ to: ____________ **

☐ Student may carry INHALER / EPIPen (circle choice) and use as prescribed by licensed provider.

*Licensed Prescriber signature: ___________________________ Date: ________________

Print name of Licensed Prescriber: __________________________________________________

Telephone # of Licensed Prescriber: _________________________________________________

I do hereby release, discharge, and hold harmless, the Whitehall-Coplay School District, its agents and employees, from any and all liability claim for the administration of the above medication to my child and for any and all injuries resulting there from. I consent for employees of Whitehall-Coplay School District to exchange information regarding this medication with the physician who ordered the medication. Please refer to the school calendar for policies related to medications.

Parent/Guardian signature: ___________________________ Date: ________________

*If the dosage is changed at any time, physician must complete new form. Please request additional forms as needed from the school nurse or obtain on-line at www.whitehallcoplay.org.

**This form is only valid for school year in which it was completed.
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