Whitehall-Coplay School District

Emergency Action Plan (EAP) ~ Severe Allergic Reaction

Place Child's Photo Here

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: _____

Treatment

Give: _____
(medication/dose/route)

Give: _____
(medication/dose/route)

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.

Food Allergy Action Plan

Student's Name: _____ D.O.B: _____ Teacher: _____
Allergy to: _____ Asthmatic: Yes* ☐ No ☐ *Higher risk for severe reaction

Place Child's Picture Here

■ STEP 1: TREATMENT ■

Symptoms:		Give Checked Medication**: **(To be determined by physician authorizing treatment)
▪	If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ Heart†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other†	_____	☐ Epinephrine ☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one, and see reverse side for instructions)
EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg Adrenaclick™ 0.3 mg Adrenaclick™ 0.15 mg
Antihistamine: give (medication/dose/route) _____
Other: give (medication/dose/route) _____
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 an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number: _____
3. Parent _____ Phone Number(s): _____
4. Emergency contacts:
   a. Name/Relationship _____ Phone Number: _____
   b. Name/Relationship _____ Phone Number: _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____
(Required)

Staff Members Trained in Epinephrine Administration:

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.

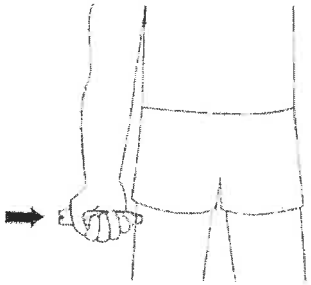
_____Medication Authorization forms (signed by both the parent and physician) for each medication needed in school.

Parent/Guardian's Signature_____ Date_____

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector 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 the EPIPEN Auto-Injector and massage the area for 10 more seconds

EPIPEN 2-PAK | EPIPEN Jr 2-PAK

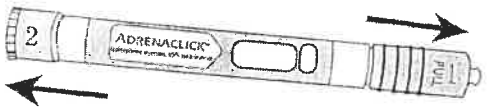
Twinject® 0.3 mg and Twinject® 0.15 mg Directions

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

SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

- 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.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg 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.

Once epinephrine is used, call the Rescue Squad and request an ambulance equipped with epinephrine and a responder trained to administer this medication. 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.*

FAAN

Feb. 2010

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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