BLUE SPRINGS R-IV SCHOOL DISTRICT

ALLERGY ACTION PLAN

Student Name:	D.O.B:	Teacher:
Allergy to:		
Asthmatic (Check Yes or No) ☐ YES* ☐ NO *Higher risk for severe reaction		

STEP 1: TREATMENT

SYMPTOMS	GIVE CHECKED MEDICATION	
☐ If exposure has occurred, but no symptoms	☐ Epinephrine	☐ Antihistamine
☐ Mouth	☐ Epinephrine	☐ Antihistamine
☐ Skin	☐ Epinephrine	☐ Antihistamine
☐ Gut	☐ Epinephrine	☐ Antihistamine
☐ Throat †	☐ Epinephrine	☐ Antihistamine
☐ Lung †	☐ Epinephrine	☐ Antihistamine
☐ Heart †	☐ Epinephrine	☐ Antihistamine
☐ Other †	☐ Epinephrine	☐ Antihistamine
☐ If reaction is progressing, give:	☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. This symbol (†)represents potentially life-threatening

DOSAGE:

Epinephrine: inject intramuscularly
(See second page for instructions)

Antihistamine, give:

Medication Dose Route

Other, give:

Medication Dose Route

Doctor's Signature (required): Date:

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

TO BE COMPLETED BY THE PARENT/GUARDIAN

The following policy has been established for Epinephrine dispensed in emergency situations.

1. This form must be completed and signed by the student's physician and parent/guardian before the registered nurse, LPN or other trained district personnel is authorized to administer the Epinephrine. This authorization form must be renewed each school year.
2. A District RN, LPN or other trained district personnel may administer Epinephrine. Trained students may also self-administer the Epinephrine. The district policy requires 911 emergency numbers be called to get emergency medical assistance (EMS) if the Epinephrine is administered. determined by the parent. Correction doses should not be delivered sooner than two hours from the previous correction dose.

I have read the guidelines and authorize the RN, LPN, other trained district personnel or EMS personnel to administer the above medication as prescribed by the physician. This medicine is to be furnished by me and will be labeled with the student's name, name of medicine, amount to be given, route of administration and physician's name.

Expiration Date of Medicine:	**Parent/Guardian Signature**	**Date**