

EDMOND PUBLIC SCHOOLS
Allergy Medical Management and Emergency Action Plan

Name _____ DOB _____ School Year _____
Teacher _____ Grade _____

ALLERGY TO _____

Asthmatic? Yes* No *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms

Give Checked Medication

- | | | |
|---|--------------------------------------|--|
| • If a food allergen has been ingested, but no symptoms: | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Mouth - Itching, tingling, or swelling of lips, tongue, mouth: | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Skin – Hives, itchy rash, swelling of the face or extremities: | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Gastrointestinal – Nausea, abdominal cramps, vomiting, diarrhea: | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Throat – Tightening of throat, hoarseness, hacking cough: | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Lung – Shortness of breath, repetitive coughing, wheezing: | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Heart – Weak pulse, low blood pressure, fainting, pale, blueness: | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Other _____ | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

DOSAGE

Epinephrine: Inject intramuscularly

___ Epi-pen 0.3mg ___ Epi-pen JR 0.15 mg ___ Twinjet 0.3 mg ___ Twinjet 0.15 mg ___ Auvi-Q 0.3 mg ___ Auvi-Q 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. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Parent _____ Phone Number _____

3. Emergency Contacts:

Name/Relationship	Phone Number (s)	
_____	1. _____	2. _____
_____	1. _____	2. _____

I give permission to the school nurse and other staff members of _____ School to perform and carry out the emergency care tasks as outlined by _____'s Allergy Medical Management Plan. I also consent to the release of the information contained in this Allergy Medical Management Plan to all school staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Parent/Guardian _____ Date _____

Acknowledged and received by:

School Nurse _____ Date _____