Place Student's Picture Here

SEVERE **ALLERGY** ACTION PLAN
FOR SCHOOL PERSONNEL

Student: _____ Grade: ____ DOB: _____
Teacher: _____ Classroom: _____ SCHOOL YEAR: _____

SEVERE ALLERGY TO: _____

Asthmatic: YES ☐* NO☐ * Higher risk for severe reaction

STEP 1: RECOGNIZE THE SYMPTOMS

If _____ shows **the following symptoms as check by doctor:**

Symptoms: (Doctor, please select by checking all symptoms that require Epinephrine Auto-Injector administration)

- ☐ **Mouth** itching, tingling or swelling of the lips, tongue, mouth
- ☐ **Throat** tightening of throat, hoarseness, hacking cough
- ☐ **Skin** hives, itchy rash, swelling of the face or extremities
- ☐ **Gut** nausea, abdominal cramps, vomiting, and diarrhea
- ☐ **Lung** shortness or breath, repetitive coughing, wheezing
- ☐ **Heart** weak or thready pulse, low blood pressure, fainting, pale, blueness
- ☐ **Other** _____

STEP 2: RESPOND

Give Epinephrine Auto-Injector as directed per Authorization for Medication Form.

(Doctor, please select by checking dosage to be administered)

☐ **Epinephrine Auto-Injector** (0.15mg epinephrine)
OR
☐ **Epinephrine Auto-Injector** (0.3mg epinephrine)

Administer rescue breathing or CPR, if necessary.

STEP 3: EMERGENCY CALLS

1. **Call 911**
2. **Call Emergency Contacts:**

Name/Relationship	Phone Number	Alternate Phone Number
1.	1.	1.
2.	2.	2.
3.	3.	3.

_____ _____
Doctor Signature **Date** **Parent/Guardian Signature** **Date**

Revised 07/2014
Form adopted from the Food Allergy & Anaphylaxis Care Plan.

Florida HEALTH
Miami-Dade County

FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE
SCHOOL HEALTH PROGRAM
ROLES AND RESPONSIBILITIES: SEVERE ALLERGIES

Student: _____ **DOB:** _____ **Teacher:** _____ **Grade:** _____

Parent/Guardian & Phone(s): _____ **School Year:** _____

SEVERE ALLERGY ACTION PLAN: Follow the attached physician action plan.

School Responsibilities/Agreements	Family Responsibilities/Agreements	Student Responsibilities/Agreements
1. Epinephrine auto injector Kept: Staff authorized to administer epinephrine auto injector **(review plan, recognize symptoms and respond):**	1. Provide medication for school site/replace any expired medication. **Exp. Date:** _____	1. Report any signs/symptoms
2. Staff to administer medications per MDCPS training:	2.Keep school staff informed of any changes in student condition or medications	2. Do not trade food with others
3. Staff to contact 911/parent/guardian:	3. Available to accompany student on field trip and carry the epinephrine auto injector (complete school volunteer form). Alternate for parent/guardian (complete volunteer form):	3. **If applicable**, carry epinephrine auto injector as directed by physician.
4. Staff to direct EMS to the emergency	4. **(Severe Food Allergies)** Provide all meals/snacks for student	
5. CPR certified staff:	5. **If applicable**, check student is carrying epinephrine auto injector as directed by physician	
6. Prevention at school site: School grounds: Control of insects Contact MDCPS Safety, Environment, Hazards Management Cafeteria: _____ free table or clean table with single use paper towel with MDCPS approved cleanser. Cafeteria Manager: Teacher/paraprofessional to carry school two- way radio		
7. Substitute teacher instructions:		

_____ _____
Parent/Guardian Signature Date

_____ _____
Principal or School Administration Designee Date

_____ _____
School Nurse Date

FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE COUNTY
SCHOOL HEALTH PROGRAM
HEALTH HISTORY AND CONSENT-SEVERE ALLERGY

Student: _____ **DOB**_____ **Teacher:** _____ **Grade:** _____
School: _____ **Parent/Guardian & Phone(s):** _____
Physician & Phone: _____ **School Year:** _____
KNOWN ALLERGIES: _____

Dear Parent/Guardian:
School records or medical information indicates your child has allergies or a severe allergy. In order to attend to your child's health and safety, the school requires a health history. Please return this form to the nurse as soon as possible. It will become part of your child's confidential school health record. Our primary concern is that your child's healthcare needs are met while in school.

_____ _____ _____
School Nurse Phone number Date

1. **What is your child allergic to?** (Circle all that apply)
Insect bites- bees, wasps, hornets, yellow jackets, fire ants, mosquitoes, spiders, other: _____
Foods- peanuts, all nuts, milk, all dairy, eggs, wheat, soy, chocolate, mango, shellfish, fish, other: _____
Latex rubber **and/or** any **Medications** (list) _____
Other Allergen- pollen, dust, smoke, animal dander, chemical fumes, other: _____
2. How many times has your child had an allergic reaction? ☐Once ☐ 2-3 times ☐ other _____
3. Has your child ever been hospitalized for a severe reaction? ☐No ☐Yes If yes, when? _____
4. Describe your child's usual symptoms: _____
5. How have you treated allergic reactions? _____
6. List any medications your child takes daily for allergies:

Name of Medication	Dosage	Time

Does your child have any "as needed" medications or **emergency medications**? _____
7. Does your child take any **other** medications?

Name of Medication	Dosage	Time

8. List any side effects your child experiences from his/her medication? _____
9. Self-Care: Please circle responses

a.	Is your child able to monitor and prevent their own exposures?	No	Yes
b.	Does your child:		
	1. Know what foods to avoid	No	Yes
	2. Ask about food ingredients	No	Yes
	3. Read and understands food labels	No	Yes
	4. Tell an adult immediately after an exposure	No	Yes
	5. Wear a medical alert bracelet, necklace, watchband	No	Yes
	6. Firmly refuses a problem food	No	Yes
c.	Does your child know how to use emergency medication?	No	Yes
d.	Has your child ever administered their own emergency medication?	No	Yes

CONSENT

Please circle your response and sign:**(I do /I do not) give the School Nurse my permission to share information relevant to my child's medical status with school staff on a "need to know" basis, if she/he determines that this information is necessary to assure my child's health and safety.**

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____