THE INDIANA ACADEMY FOR SCIENCE, MATHEMATICS, AND HUMANITIES

*This page is required **ONLY** if your child has a current diagnosis of Severe/Life Threatening Allergies OR your provider may provide his/her own Action Plan*

2020-2021

SEVERE ALLERGY & ANAPHYLAXIS ACTION PLAN: Residential & Non-Residential Students

- This section MUST be completed by the Allergy Care Provider (not the parent/guardian)

Student's Name: _____

Extremely Reactive to the Following Allergens:

1.	3.	5.
2.	4.	6.

Medications:

	Medication Name:	Dosage:	Special Instructions/Directions:
Epinephrine	☐ Epipen Auto-Injector ☐ Auvi Q ☐ Adrenaclick	☐ 0.15mg OR ☐ 0.30mg	
Antihistamine	☐ Claritin ☐ Zyrtec ☐ Allegra ☐ Benadryl ☐ Other		
Inhaler	1. 2.		
Other			

Action Plan:

1. If Epinephrine is prescribed, please check at least one of the following:
   ☐ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for ANY symptoms.
   ☐ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.
2. Inject Epinephrine (if prescribed).
3. Call 911 if Epinephrine used. Request an ambulance with Epinephrine.
4. Give additional medications if prescribed (if conscious & able to swallow).
   - Antihistamines
   - Inhaler
5. Lay student flat & raise legs. If breathing is difficult or student is vomiting, let him him/her sit up or lie on side.
6. If symptoms do not improve or symptoms return, more doses of Epinephrine can be given at least 5 minutes or more after the last dose.
7. Stay with student.
8. Transport to ER via ambulance even if symptoms resolve. Student should remain in ER for approximately 4+ hours in case symptoms return.
9. Notify parent/guardian.

Self-Administration: (please check one)

_____ Student can carry & use the medication listed above at school without supervision.

_____ Student needs supervision or assistance with the above medication at school.

Physician/Provider:

Address: _____Date: _____

Phone #: _____ Fax #: _____ Email: _____

Provider Signature: _____ Provider Printed Name _____

I, the parent/guardian, give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact the allergy care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with the prescribed medication and delivery/monitoring devices:

Parent Signature: _____ Parent Printed Name _____

CC: Tina Brinkman, RN/Nikki Al Khatib, RN