Byram Hills Central School District
Health Services Department
ALLERGY ACTION PLAN

Place Child's picture here

LAST NAME _____ **FIRST NAME** _____ **DOB** _____

School _____ **Grade** _____ **Teacher / and/or Counselor** _____

ALLERGIC TO: _____

Asthmatic ___**Yes*** ___**No** ***High risk for severe reaction**

To be determined by physician

STEP 1 TREATMENT

SYMPTOMS		Give Checked Medication	
[ ] Mouth	itching and swelling of the lips, tongue, or mouth	[ ]Epi Pen	[ ]Antihistamine
[ ]Throat	tightening of throat, hoarseness, hacking cough	[ ]Epi Pen	[ ]Antihistamine
[ ]Skin	hives, itchy rash, swelling of the face or extremities	[ ]Epi Pen	[ ]Antihistamine
[ ]GI	nausea, abdominal cramps, vomiting, and/or diarrhea	[ ]Epi Pen	[ ]Antihistamine
[ ]Lung	shortness of breath, repetitive coughing, wheezing	[ ]Epi Pen	[ ]Antihistamine
[ ]Heart	"thready" pulse, "passing-out"	[ ]Epi Pen	[ ]Antihistamine

[ ]Other _____

[ ]Mild Allergic Reaction **[ ]No treatment necessary**

NOTE TO STAFF: THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. *ALL ABOVE SYMPTOMS CAN POTENTIALLY PROGRESS TO A LIFE-THREATENING SITUATION!

Specific Order:

EPINEPHRINE: inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

ANTIHISTAMINE: give _____
medication/dose/route

Other: give _____
medication/dose/route

[ ] This child has a history of mild allergic reaction(s) and no treatment is necessary.

[ ] This child has been trained and is competent to self administer EpiPen.

STEP 2 EMERGENCY CALLS

1. **CALL 911: State that an allergic reaction has been treated, and additional emergency care may be needed.**
2. **Call Dr.** _____ **at** _____**(telephone number)**
3. **Emergency Contact: name/relationship to student** **Daytime Phone#** **Cell Phone #**

a. _____ _____ _____
Parent / Guardian

b. _____ _____ _____

c. _____ _____ _____

NOTE TO STAFF: DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 EVEN IF PARENTS CANNOT BE REACHED!!

****Parent/Guardian Signature (required)** _____ **Date:** _____

Doctor's Signature (required) _____ **Date:** _____

****The signing and submission of this Action Plan also gives the School Health Services Staff authorization to discuss this condition with the physician whose signature appears on this form limited to the current school year.**

STAFF MEMBERS TRAINED IN EPIPEN ADMINISTRATION (to be completed by school staff)

_____ **Room #** ___ **Phone #** _____
Name of staff member

_____ **Room #** ___ **Phone #** _____
Name of staff member

_____ **Room #** ___ **Phone #** _____
Name of staff member

EPIPEN® AND EPIPENJR® DIRECTIONS/MAY BE ADMINISTERED THROUGH CLOTHING

1. **PULL OFF GRAY SAFETY CAP. ONLY HOLD THE DEVICE AROUND THE BARREL. DO NOT TOUCH THE ENDS.**

2. **PLACE BLACK TIP ON OUTER THIGH (ALWAYS APPLY TO THIGH).**

3. **USING A QUICK MOTION, PRESS FIRMLY INTO OUTER THIGH UNTIL AUTO-INJECTOR MECHANISM FUNCTIONS. HOLD IN PLACE AND COUNT TO 10 SLOWLY. THE EPIPEN® UNIT SHOULD THEN BE REMOVED. MASSAGE THE AREA FOR 10 SECONDS. TAKE THE EPIPEN® UNIT WITH YOU TO THE EMERGENCY ROOM.**

4. **FOLLOW THROUGH WITH TRANSFER OF CARE TO EMERGENCY MEDICAL SERVICES.**