Ramapo Indian Hills Regional High School District

Ramapo High School
(201) 891-1500, X-2275

Indian Hills High School
(201) 337-0100, X-3375

Allergy Action Plan

Student's Name:_____ D.O.B:_____ Teacher:_____

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

Place Child's Picture Here

◆ STEP 1: TREATMENT ◆

Symptoms:		Give Checked Medication**: **(To be determined by physician authorizing treatment)
▪	If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ Heart†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other†	_____	☐ Epinephrine ☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

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 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number: _____
3. Parent_____ Phone Number(s) _____
4. Emergency contacts:

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

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

TRAINED STAFF MEMBERS

1. _____ Room _____

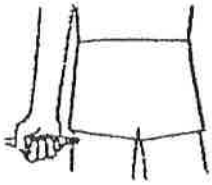
2. _____ Room _____

3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.

- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

- Remove caps labeled "1" and "2."

- Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

- Slide yellow collar off plunger.

- Put needle into thigh through skin, push plunger down all the way, and remove.

Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

The Food Allergy & Anaphylaxis Network

June/2007

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PARENT/GUARDIAN REQUESTFOR STUDENT SELF-MEDICATION

Dear: _____
Principal

I hereby authorize my child _____, who attends INDIAN HILLS/Ramapo HIGH SCHOOL grade _____, to self-medicate during school hours as prescribed by our family physician in the attached certification for asthma or other potentially life threatening illness (epi-pen).

I shall provide the prescribed medication in the original container indicating the name of the patient, name of prescription, dosage, time, physician's name and date prescription was issued.

I understand that for purposes of self-administration of medication, life threatening illness means an illness or condition that requires an immediate response to specific symptoms or sequelae that if left untreated may lead to potential loss of life. Self-administration of medication shall include the use of inhalers to treat an asthma attack or the use of an epi-pen to treat a potential anaphylactic reaction. If my child is directed to self-medicate only in the case of life-threatening illness, I shall provide an additional supply of medication to the nurse.

I understand that all medications shall be brought to the school nurse by the parent/guardian and shall be picked up at the end of the school year or end of the period of medication, whichever is earlier, by the parent/guardian.

I have been informed, in writing, by the Ramapo Indian Hills Board of Education that the school district and its agents, servants, officers and employees shall incur no liability whatsoever for any and all claims, damages, losses and expenses of any kind, including reasonable attorney's fees as a result of injury arising from the self-administration of medication by my child.

I hereby indemnify and hold harmless the Ramapo Indian Hills Board of Education, its agents, servants, officers and employees of any and all liability whatsoever for any and all claims, damages, losses and expenses of any kind, including reasonable attorney's fees as a result of any injury arising from self-administration of medication by my child.

I acknowledge that the district shall not incur any liability whatsoever as a result of any injury arising from the self-administration of medication by my child and that I shall indemnify and hold harmless the district and its employees or agents from any claims arising out of the self-administration of medication by my child.

_____ _____
Parent/Guardian Signature Date

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EMERGENCY ADMINISTRATION OF THE EPI-PEN

Dear : _____
Parent/Guardian

The Ramapo Indian Hills Board of Education hereby informs you that if Board-approved procedures are followed, the District and its employees shall incur no liability whatsoever for any and all claims, damages, losses and expenses of any kind, including reasonable attorneys' fees as a result of any injury arising from the emergency administration of the epi-pen.

I, _____, hereby acknowledge that, if the District procedures are followed, the District shall incur no liability whatsoever for any and all claims, damages, losses and expenses of any kind, including reasonable attorneys' fees as a result of any injury which arises from the emergency administration of the epi-pen. I, _____, hereby indemnify and hold harmless the District and its employees, officers or agents against any and all claims arising from the emergency administration of the epi-pen.

I, _____, hereby acknowledge that if the epi-pen is administered to my child, District policy and procedures require that he/she receive immediate medical care following the administration of the epi-pen.

I, _____, hereby further agree to assume full financial responsibility for any and all costs in connection with the medical care provided to my child, including but not limited to, transportation expense to and from a medical facility.

_____ _____
Parent/Guardian Date