

**Verona Public Schools  
Allergy Action Plan**

Student Name \_\_\_\_\_ D/O/B \_\_\_\_\_  
ALLERGIC TO \_\_\_\_\_ Weight \_\_\_\_\_ School Year \_\_\_\_\_  
Asthmatic? \_\_\_ Yes\* \_\_\_ No (\* High Risk for severe reaction)

**> SIGNS OF ALLERGIC REACTION**

<u>SYSTEMS</u>	<u>SYMPTOMS</u>		
<b>MOUTH</b>	Itching and swelling of lips, tongue or mouth/Angioedema	___ Antihistamine	___ Epinephrine
<b>SKIN</b>	Hives, itchy rash, &/or swelling of face or extremities	___ Antihistamine	___ Epinephrine
<b>THROAT</b>	Itching &/or tightness in throat, hoarseness, hacking cough	___ Antihistamine	___ Epinephrine
<b>GUT</b>	Nausea, abdominal cramps, vomiting &/or diarrhea	___ Antihistamine	___ Epinephrine
<b>LUNG*</b>	Shortness of breath, repetitive cough, wheeze, chest tightness	___ Antihistamine	___ Epinephrine
<b>HEART*</b>	Thready pulse, 'Passing out'	___ Antihistamine	___ Epinephrine

The severity of symptoms can change quickly - All above symptoms can potentially progress to a life threatening situation.

**> ACTION FOR A MINOR REACTION:**

1. If only symptoms are MINOR rash or skin itching, give **Diphenhydramine** \_\_\_\_\_  
( **POSSIBLE SIDE EFFECT: SEDATION** )
1. Then call emergency contacts on file as provided by parents or guardians.

**> ACTION FOR A MAJOR REACTION:**

1. **If symptoms progress &/or person has cough, hoarseness of voice, tightness of throat, wheezing &/or shortness of breath, IMMEDIATELY give:**  
Epinephrine auto-injector \_\_\_ **0.15 mg syringe**, entire contents I.M. into lateral thigh  
Epinephrine auto-injector \_\_\_ **0.30 mg syringe**, entire contents I.M. into lateral thigh  
(POSSIBLE SIDE EFFECTS: RAPID HEART RATE, TREMORS)
1. **THEN CALL: 9-1-1 - ASK FOR ADVANCED LIFE SUPPORT.**
2. **Call Emergency Contacts on file as provided by parents or guardians**  
**IF THERE IS AN INADEQUATE RESPONSE TO INITIAL EPINEPHRINE INJECTION WITHIN 5 MINUTES,**  
**ADMINISTER SECOND DOSE.**

The student is both capable and responsible for administering this Epinephrine: \_\_\_ YES \_\_\_ NO  
IN THE ABSENCE OF A SCHOOL NURSE, THE ORDER FOR ANTIHISTAMINE SHOULD BE DISREGARDED AND EPINEPHRINE ADMINISTERED BY DESIGNATED SUBSTITUTE.

Physician Name (print) \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Stamp

This acknowledges that the district shall incur no liability as a result of any injury arising from administration of medication and that I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of medication.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian's Signature