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

SYSTEMS	**SYMPTOMS**	
MOUTH	Itching and swelling of lips, tongue or mouth/Angioedema	___Antihistamine ___Epinephrine
SKIN	Hives, itchy rash, &/or swelling of face or extremities	___Antihistamine ___Epinephrine
THROAT	Itching &/or tightness in throat, hoarseness, hacking cough	___Antihistamine ___Epinephrine
GUT	Nausea, abdominal cramps, vomiting &/or diarrhea	___Antihistamine ___Epinephrine
LUNG*	Shortness of breath, repetitive cough, wheeze, chest tightness	___Antihistamine ___Epinephrine
HEART*	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 (hold for 3 seconds)
   Epinephrine auto-injector____0.30 mg syringe, entire contents I.M. into lateral thigh (hold for 3 seconds)
   (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