

# LISD Allergy Action Plan for Secondary Students

Place  
Student's  
Picture  
Here

Name: \_\_\_\_\_ D.O.B \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Campus: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher \_\_\_\_\_

Severe Allergy to: \_\_\_\_\_

Student history and warning signs: \_\_\_\_\_

Does Student Have Asthma? \_\_\_ Yes \_\_\_ No

MILD SYMPTOMS	
<b>Skin:</b>	a few hives, mild itching
<b>Mouth:</b>	itchy mouth
<b>Stomach:</b>	mild nausea or discomfort
<b>Nose:</b>	itchy, runny nose, sneezing

SEVERE SYMPTOMS	
<b>Skin:</b>	many hives all over, redness, swelling of face, eyes, or lips
<b>Lung:</b>	short of breath, wheezing, repetitive cough
<b>Throat:</b>	tight, hoarse, trouble breathing or swallowing
<b>Mouth:</b>	swelling of tongue and/or lips
<b>Stomach:</b>	vomiting, diarrhea, severe cramping
<b>Heart:</b>	pale, blue, faint, weak pulse, dizzy, confusion, loss of consciousness
<b>Others:</b>	anxiety, feeling bad, or feeling of impending doom

### TREATMENT PLAN

(TWO CHOICES – PLEASE CHECK ONLY ONE):



**Plan 1: For MILD SYMPTOMS:**

Mild symptoms from **MORE THAN ONE BODY AREA** (skin, mouth, stomach, or nose) are **TREATED AS SEVERE SYMPTOMS!!!** Give **EPINEPHRINE**.

Mild Symptoms from a **single** body area:

1. Give **Antihistamine** if ordered.
2. Stay with student and monitor for worsening symptoms.
3. If symptoms progress, **USE EPINEPHRINE** (treat as **SEVERE** symptoms).
4. Contact parent.

**For SEVERE SYMPTOMS:**

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.**
3. Give **Antihistamine** and then **Inhaler** if ordered (and not already used).
4. Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
5. If symptoms do not improve, or return, more epinephrine may be needed. See order if you need to repeat the dose and when dose is to be repeated.
6. Contact parent.

**OR**

**Plan 2: Give Epinephrine immediately for ANY symptoms if the allergen was likely eaten :**

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.**
3. Give **Antihistamine** and then **Inhaler** if ordered.
4. Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
5. If symptoms do not improve, or return, more epinephrine may be needed. See order if you need to repeat the dose and when dose is to be repeated.
6. Contact parent.

### ORDERED MEDICATIONS AND DOSES

**Student may self-carry & administer medications and has been instructed on proper use Y N**

**Antihistamine Brand:**

[ ] Benadryl or Diphenhydramine  
 [ ] Other: \_\_\_\_\_

**Antihistamine Dose:**

[ ] 12.5 mg [ ] 18.75 mg [ ] 25 mg  
 [ ] 31.25 mg [ ] 37.5 mg [ ] 43.75 mg  
 [ ] 50 mg

**Nurses Notes:** \_\_\_\_\_ mg = \_\_\_\_\_

Medication is kept: \_\_\_ with student \_\_\_ in clinic \_\_\_ both

**EPINEPHRINE Dose:**

[ ] 0.15 mg IM [ ] 0.3 mg IM

Type of injector: \_\_\_\_\_

[ ] If not improved, give second dose of Epinephrine in \_\_\_\_\_ minutes.

[ ] Student will not have second dose of Epinephrine at school. \_\_\_\_\_ Parent's Initials

Medication is kept: \_\_\_ with student \_\_\_ in clinic \_\_\_ both

**Inhaler:**

Brand: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Frequency: \_\_\_\_\_

Indication for use: \_\_\_\_\_

Medication is kept: \_\_\_ with student \_\_\_ in clinic \_\_\_ both

I request and authorize Lewisville ISD personnel to administer the above medication as prescribed. I understand that the school administrator may designate any qualified person or persons to administer these medications. This form is valid for one school year. Physician must be licensed to practice in Texas. Temporary (2 months) orders for out of state US Physicians are acceptable to initiate treatment for transferring students. A signature is required to authorize the registered nurse and the prescribing physician to discuss and/or clarify the medication order and the student's response to the treatment plan. Elementary students are not permitted to transport medications. Unused medications not picked up at the end of the school year will be disposed of properly.

Physician Signature: _____	Printed Name: _____	Parent Signature: _____
Date: _____	Office #: _____	Fax #: _____
Address: _____		

Revised 5/18 Epinephrine Expires: \_\_\_\_\_ Lot #: \_\_\_\_\_ Benadryl Expires: \_\_\_\_\_ Inhaler Expires: \_\_\_\_\_