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	
Skin:	a few hives, mild itching
Mouth:	itchy mouth
Stomach:	mild nausea or discomfort
Nose:	itchy, runny nose, sneezing

SEVERE SYMPTOMS	
Skin:	many hives all over, redness, swelling of face, eyes, or lips
Lung:	short of breath, wheezing, repetitive cough
Throat:	tight, hoarse, trouble breathing or swallowing
Mouth:	swelling of tongue and/or lips
Stomach:	vomiting, diarrhea, severe cramping
Heart:	pale, blue, faint, weak pulse, dizzy, confusion, loss of consciousness
Others:	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. **ADMINISTER EPHINEPHRINE 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. **ADMINISTER EPHINEPHRINE 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
[ ] 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** **OTHER**_____**mg**

Nurses Notes: _____**mg =** _____
Medication is kept: ___with student ___in clinic ___ both

EPINEPHRINE Dose:

Injectable [ ] 0.15 mg IM [ ] 0.3 mg IM
Inhalation [ ] 1 mg [ ] 2 mg

Method Administered: Injection Inhalation

[ ] 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:** _____
Date: _____ **Office #:** _____ **Fax #:** _____
Address: _____

Parent Signature: _____
Date: _____

 Epinephrine Expires: _____ **Lot #:** _____ **Antihistamine Expires:** _____ **Inhaler Expires:** _____