Place Child's Picture Here

SEVERE ALLERGY ACTION PLAN

Student Name_____ D.O.B._____

ALLERGY TO_____

- Please check all that apply: ☐ Ingestion ☐ Contact ☐ Airborne
- Is the student **asthmatic?** ☐ Yes ☐ No

Students with **asthma** are at higher risk for severe reactions. **(Please complete the *Authorization for the Possession and use of Asthma Inhaler/Other Emergency Medication(s)* form (Form 5330 F3).**

❖ SIGNS OF AN ALLERGIC REACTION

Systems:	Symptoms:	Give Checked Medication:
•**MOUTH**	Itching, tingling, or swelling of the lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
•**THROAT**	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
•**SKIN**	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
•**GUT**	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
•**LUNG**	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
•**HEART**	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
•**OTHER**	_____	☐ Epinephrine ☐ Antihistamine

☐ I have completed Form 5330 F4 (*Authorization for the Possession and Use of Epinephrine Autoinjector (Epi-Pen*).

☐ I have completed Form 5330 F3 (*Authorization for the Possession and Use of Asthma Inhaler/Other Emergency Medication(s*).

☐ I have completed Form 5330 F1 (*Parent Request and Authorization to Administer a Prescribed Medication/Drug/or Treatment*).

_____
Physician's Name

_____
Physician's Signature

_____
Address of Clinic

_____

_____
Clinic Telephone

_____
Clinic Fax

_____
Date

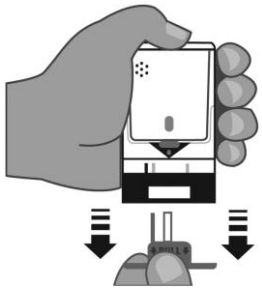
_____
Parent/Guardian Name

_____
Parent/Guardian Signature

_____
Parent/Guardian Telephone #1

_____
Parent/Guardian Telephone #2

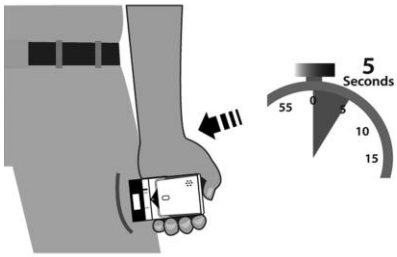
Auvi-Q™ (epinephrine injection, USP) Directions



Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
Pull off RED safety guard.

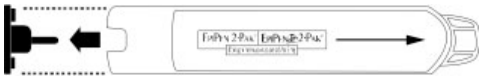
Place black end against outer thigh, then press firmly and hold for 5 seconds.

Auvi-Q™
epinephrine injection, USP
0.15 mg/0.3 mg auto-injectors

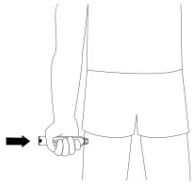


EpiPen® (epinephrine) Auto-Injector Directions

- **First, remove the EpiPen® (epinephrine) Auto-Injector from the plastic carrying case**



- **Pull off the blue safety release cap**
- **Hold orange tip near outer thigh (always apply to thigh)**



- **Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.**

Remove EpiPen® (epinephrine) Auto-Injector and massage the area for 10 more seconds.

- **Call 911, School Nurse and Parent. Send used epi-pen to Emergency Room with student.**

EpiPen 2-Pak® EpiPen Jr 2-Pak®
(Epinephrine) Auto-Injectors 0.3/0.15mg

A severe allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Severe Allergy Action Plan.
A kit must accompany the student if he/she is off school grounds (i.e., field trip

Form adapted from the Food Allergy Research & Education (FARE) (www.foodallergy.org) 4/2013