Lincoln Park Performing Arts Charter School

Health Services

LIFE-THREATENING ALLERGY ACTION PLAN

NAME:		Severe ALLERGY to: Other Allergies:
Please list the specific symptoms the student has experienced in the past:		Asthma ☐ Yes (High risk for severe reaction) ☐ No
School Year:	Date of Birth: Grade:	Routine medications (at home/school):
Bus#	Car ☐ Walk ☐ Date of last reaction:	

Location(s) where Epipen®!Rescue medications is/are stored:

☐ Health Office ☐ Backpack ☐ Other_____

Allergy Symptoms: If you suspect a severe allergic reaction, immediately ADMINISTER Epinephrine and ca11 911

MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
THROAT	Sense of tightness in the throat, hoarseness, and hacking cough
GUT	Nausea, stomachache/abdominal cramps, vomiting, and/or diarrhea
LUNG	Shortness of breath, repetitive coughing, and/or wheezing
HEART	"Thready" pulse, "passing out," fainting, blueness, pale
GENERAL	Panic, sudden fatigue, chills, fear of impending doom
OTHER	Some students may experience symptoms other than those listed above

MEDICATION ORDERS:

EpiPen® (0.3) ☐ EpiPen Jr.® (0.15) ☐	Other epi injector:
Repeat dose of EpiPen®: ☐ Yes ☐ No	If YES, repeat when:
Antihistamine (name)_____	Give:_____Teaspoons_____Tablets by mouth How often:

- It is medically necessary for this student to carry an Epipen® during school hours. ☐ Yes ☐ No
- Student may self-administer Epipen®. ☐ Yes ☐ No
- Student has demonstrated use to RN ☐ Yes ☐ No

GIVEN:
DATE:
TIME:

ACTION PLAN

- GIVE MEDICATION AS ORDERED ABOVE. AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.
- NOTE TIME_____AM/PM (Epipen®/adrenaline given) • NOTE TIME_____AM/PM (Antihistamine given)
- CALL 911 IMMEDIATELY. 911 must be called WHENEVER Epipen® is administered.
- DO NOT HESITATE to administer Epipen® and to call 911 even if the parents cannot be reached.
- ALERT 911 student is having a severe allergic reaction and Epipen® is being administered.
- An adult trained in CPR is to stay with student-monitor and begin CPR if necessary .
- Call the School Nurse at x1685 or main office at x1370 immediately
- Student should remain with a staff member trained in CPR at the location where symptoms began until EMS arrives.
- NOTIFY administration and parent/guardian ASAP.

BUS: (Bus transportation will be alerted to student's allergy)

- This student carries Epipen® on the bus: ☐ Yes ☐ No
- Epipen® can be found in: ☐ Backpack
- Student will sit at front of the bus: ☐ Yes ☐ No
- Other (specify): _____

FIELD TRIP: (Epipen® should accompany student during any off campus activities)

- Student should remain with the teacher or parent/guardian during the entire field trip: ☐ Yes ☐ No
- Staff members on trip must be trained regarding Epipen® use and student action plan (plan must be taken).
- Other (specify) _____

CLASSROOM: For Food allergy only)

- Student is allowed to eat only the following foods in the classroom:

☐ Those in manufacturer's packaging with ingredients listed and determined allergen-safe by the nurse/parent or _____

☐ Those approved by parent.

☐ Middle school or high school student will be making his/her own decision.

☐ Alternative snacks will be provided by parent/guardian to be kept in the classroom

☐ Parent/guardian should be advised of any planned parties as early as possible.

☐ Classroom projects should be reviewed by the teaching staff to avoid specified allergens.

- Student should have someone accompany him/her in the hallways. Yes ☐ No ☐
- Other (specify): _____

CAFETERIA ☐ NO Restrictions

☐ Student will sit at a specified allergy table.

☐ Student will sit at the classroom table cleansed according to procedure guidelines prior to student's arrival and following student's departure.

☐ Student will sit at the classroom table at a specified location.

- Cafeteria manager and hostess should be alerted to the student's allergy.
- Other: _____

EMERGENCY CONTACTS (To be called in order listed)

1.	Relationship:	Phone:
2.	Relationship:	Phone:
3.	Relationship:	Phone:
4.	Relationship:	Phone:

Name of prescribing physician_____Phone #_____

THE SCHOOL NURSE MAY CONTACT THE DOCTOR LISTED ABOVE TO DISCUSS ANY QUESTIONS IN REGARD TO STUDENT'S ALLERGY

Parent/Guardian Signature_____Date:_____

THE SCHOOL NURSE MAY SHARE THIS ALLERGY INFORMATION WITH STUDENT'S TEACHERS

Parent/Guardian Signature_____Date:_____

THE SCHOOL WILL USE THIS INFORMATION AS AN ALLERGY ACTION PLAN TO PROVIDE THIS STUDENT'S CARE AND TREATMENT AT SCHOOL