Nixa School District Health Services

Allergy Action Care Plan

Student's Name____________________________ DOB__________ Grade/Teacher_______________ Date____________

ALLERGY TO____

Asthmatic? YES* NO *Higher Risk for severe reaction

Detailed history of allergic reaction:

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Medication Orders (to be completed by physician)

Symptoms		**Give Checked Medication**	
• Mouth	Itching, tingling or swelling of lips, tongue, mouth	Epinephrine	Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	Epinephrine	Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine
• Throat	Tightening, hoarseness, hacking cough	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
• Progressive reaction of multiple symptoms above		Epinephrine	Antihistamine

Note: The severity of these symptoms can quickly change.

Dosage (to be completed by physican)

Epinephrine: Inject intramuscularly and hold in place for 10 seconds before removing

EpiPen Jr. EpiPen Twinject 0.15mg Twinject 0.3mg Auvi-Q Jr. Auvi-Q

Adrenaclick Jr. Adrenaclick Other______________ Not necessary

Antihistamine (name/dose/route/frequency):

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Other medication (name/dose/route/frequency):

____

Emergency Contact Information

Call 911 if epinephrine has been given even if parent/guardian has not been reached and/or condition worsens.

Parent/Guardian________________________________Home______________Cell______________Work______________
Parent/Guardian________________________________Home______________Cell______________Work______________
Emergency Contact ____Cell______________Other______________

Parent/Guardian Signature **Date** **School Nurse Signature** **Date**

Physician Signature ____ **Date** ______________________________
Physician Name (printed) ____ Phone ______________________________
Physician address ____