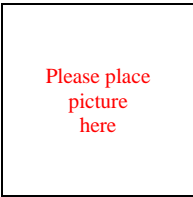


Highland Park Independent School District
Annual Physician Authorization
ALLERGY ACTION PLAN for 20__ - 20__



Student's Name _____ Grade _____ DOB _____

Allergic to _____

Ingestion
 Contact
 Airborne
 Asthmatic: YES* NO
 *Higher risk for severe reaction...

Date of last allergen challenge: _____ Wears Medic-Alert ID: YES NO

RAST score: _____

Sit in the "nut aware zone" in the cafeteria YES NO (*Elementary only*)

◆ **STEP 1: TREATMENT** ◆

Symptoms

Give Checked Medications

(To be completed by physician authorizing treatment)

If a food allergen has been ingested, but no symptoms :	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Skin: Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Throat: Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Lung: Shortness of breath, repetitive coughing, wheeze	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Heart: Thready pulse, low blood pressure, faint, pale, blueness	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Other:	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
If reaction is progressing (several of the above areas affected) give:	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine

DOSAGE:

Antihistamine: Give (check one)

Benadryl: _____ mg./cc

Other antihistamine (specify name, dosage, route) _____ give: _____

Give **antihistamine first**, observe for further symptoms and give epinephrine PRN.

Give **antihistamine and epinephrine** at the same time.

Epinephrine: Inject (IM) (check one) Epi-Pen Jr. Epi-Pen Twinject 0.3mg. Twinject 0.15mg.

For Grades 9-12:

Yes _____ No _____ This student has been trained by me (MD) and **is capable** of self-administration of the following medication(s):

Epinephrine – single dose unit
 Epinephrine and antihistamine – single dose units

Physician's signature: _____

Date: _____

Physician's stamp/printed name: _____

Annual Parent Authorization

◆STEP 2: EMERGENCY CALLS◆

1. **Call 911:** State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. **Emergency Phone Contacts:**


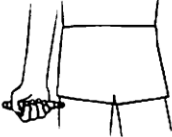




Name	Relation	Phone

3. **Dr.** _____ **Phone:** _____ **Hospital Preference:** _____

I, the undersigned parent/guardian of _____, request that an antihistamine and/or epinephrine be administered to my child, as prescribed by the physician. I understand that the School Nurse would perform this procedure. It is my understanding that if the School Nurse is not available the Principal will designate appropriate staff to perform this procedure. I will notify the school immediately if the health status of my child changes, if I change physicians, or if the procedure is canceled or changed in any way. I also give my consent to the school nurse to contact the physician or healthcare provider for additional information if needed. **In addition, I will provide a current Epinephrine auto-injector for my child's use. I understand that all Antihistamine and/or Epinephrine must be brought to school by an adult and be provided in the original container. I understand that I must communicate with the school clinic if there are any changes in management (i.e. allergy challenges or medication).**

Parent's signature: _____ Date: _____

*** Once Epi-Pen® or Twinject® is used, call 911. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.**

<p>EpiPen® and EpiPen® Jr. Directions</p> <ul style="list-style-type: none"> ▪ Pull off gray activation cap.  <ul style="list-style-type: none"> ▪ Hold black tip near outer thigh (always apply to thigh).  <ul style="list-style-type: none"> ▪ Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds. 	<p>Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions</p>  <ul style="list-style-type: none"> ▪ Pull off green end cap, then red end cap. ▪ Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove. <p>SECOND DOSE ADMINISTRATION: If symptoms don't improve after 10 minutes, administer second dose:</p> <ul style="list-style-type: none"> ▪ Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base. ▪ Slide yellow or orange collar off plunger. ▪ Put needle into thigh through skin, push plunger down all the way, and remove.   
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