Jackson Local Schools
SEVERE ALLERGY ACTION PLAN

Student's Name: ______________________________ DOB: ______________________

Grade: _______ Teacher: ______________________________ School Year: ______________________

ALLERGY TO: ____

- Does your child have an epinephrine auto-injector at school? ☐ Yes ☐ No
- Where is the epinephrine auto-injector stored? ☐ Clinic ☐ Student has authorization to carry
- Has your child been trained on the proper use of the epinephrine auto-injector? ☐ Yes ☐ No
- Can your child self-administer the epinephrine auto-injector? ☐ Yes ☐ No
- Is your child **asthmatic**? ☐ Yes (higher risk for severe reaction) ☐ No
  ** If your child is asthmatic or requires an inhaler for allergic reactions, please complete the **Asthma Action Plan**.

♦SYMPTOMS OF ALLERGIC REACTIONS♦

Mild	**Severe**	
• Hives	• Nausea/vomiting/diarrhea	• Swelling of tongue or mouth
• Itchy eyes	• Abdominal cramps	• Tingling/itching of scalp
• Nasal congestion	• Trouble breathing – wheezing, coughing	• Severe hives that get worse
• Nasal drainage	• Itching/tightness of throat	• Feeling faint, fainting episode, dusky color
	• Difficulty swallowing	

♦TREATMENT♦
(to be completed by the treating physician)

Symptoms	**Medication to be Given**	
• Exposure to allergen, but *no symptoms*	☐ Epinephrine	☐ Antihistamine
• Mouth: itching, tingling, swelling of lips/tongue/mouth	☐ Epinephrine	☐ Antihistamine
• Skin: hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
• Gastro: nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
• Throat†: tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
• Lungs†: shortness of breath, repetitive cough, wheezing	☐ Epinephrine	☐ Antihistamine
• Heart†: weak or thready pulse, low blood pressure, fainting, pale, blueness/dusky lips	☐ Epinephrine	☐ Antihistamine

†Potentially life-threatening. The severity of the symptoms can quickly change.

♦MEDICATION♦
(to be completed by the treating physician)

Epinephrine Intramuscular Injection: (circle one) Epinephrine 0.15mg Epinephrine 0.3 mg

****Note: Emergency Medical Services will be contacted if an epinephrine auto-injector is administered. ****

Antihistamine: ____
(medication/dose/route/frequency)

Other Medication: ____
(medication/dose/route/frequency)

I give permission to the school nurse and other designated staff members of Jackson Local Schools to perform the health management tasks as outlined by this Individualized Health Plan. I also consent to the release of the information contained in this plan to all staff members who have custodial care of my child and may need to know this information to maintain my child's health and safety while at school and extracurricular activities.

Parent/Guardian Signature: ______________________________ Date: ____________

Physician Signature/Phone: ______________________________ Date: ____________

Ohio Department of Health

Authorization for Student Possession and Use of an Epinephrine Autoinjector

In accordance with ORC 3313.718/3313.141

A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

Parent /Guardian signature	Date
Parent /Guardian name	Parent /Guardian emergency telephone number ( )

This section must be completed and signed by the medication prescriber.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Circumstances for use of the epinephrine autoinjector
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the prescriber)
To a student for which it is ***not*** prescribed who receives a dose

Special instructions

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ( )

Developed in collaboration with the Ohio Association of School Nurses.

HEA 4222 3/07