KNOX COUNTY SCHOOLS
HEALTH SERVICES

ALLERGY/ANAPHYLAXIS ACTION PLAN

(To be completed by a Licensed Health Care Provider)

Student Name______________________________D.O.B.________________Diagnosis/Disability________________

School_________________________

History of Asthma NO / YES (Higher risk for severe reaction)

- ☐ **IEP**
- ☐ **504**
- ☐ **IHP**

ALLERGY: (CHECK APPROPRIATE)

__ Foods (list): ____
__ Medication (list): ____
__ Latex: anaphylaxis / dermatitis (circle)
__ Stinging Insects (list): _________________________________ ** KEEP EPI-PEN WITH STUDENT WHEN OUTSIDE
__ Environmental (list): ____

RECOGNITION AND TREATMENT

If food ingested or contact w/allergen occurs: Give Checked Medication

		Epi-Pen	Antihistamine
No symptoms	*Observe / give checked medication (circle)		
MOUTH	Itching, tingling, or swelling of lip, tongue, mouth		
SKIN	Hives, itchy rash, swelling of face or extremities		
GUT	Nausea, cramps, vomiting, diarrhea		
THROAT	Tightening of throat, hoarseness, hacking cough		
RESP	Shortness of breath, coughing, wheezing		
HEART	Thready pulse, low BP, fainting, pale, cyanosis		
NEURO	Disorientation, dizziness, loss of consciousness		

DOSAGE:
Epinephrine ______________ MG

Antihistamine______________ MG

__ This student has received instruction in the proper use of the EPI-PEN and may carry.
__ This student should not carry the EPI-PEN in the school setting.

****DIETARY STATEMENT (Food allergy only)**
For school nutrition to provide substitutes of any kind, this form must contain foods to be omitted *and* substituted.

Foods to be Omitted (required)	Substitution Foods (required)	Additional Information (optional)
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Health Care Provider Signature__________________________ Date ______________________
Phone____ Fax ______________________

Side 2: Student___________________________

Parent / Guardian AUTHORIZATIONS:

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**I hereby give consent for my child to be assisted in taking the medication prescribed at school.
I authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed on this form.**

Yes / No- I want my child to carry the Epi-Pen and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of Epi-Pen. It is recommended that backup medication be stored with the school/school nurse.

Parent / Guardian Signature____
Phone_________________________________ Date___________________________________

EMERGENCY CONTACTS

	NAME	HOME #	WORK #	CELL #
PARENT/GUARDIAN				
PARENT/GUARDIAN				
OTHER:				
OTHER:				

EMERGENCY CALLS

1. **Call 911. State that an allergic reaction has been treated**
2. **Call parents/guardian to notify of reaction, treatment and student's health status**
3. **Treat for shock. Prepare to do CPR**
4. **Accompany student to ER if no parent/guardian are available.**

School Nurse ____ Date________________________