Long Hill Township Public Schools

Life Threatening Allergy Action Plan

Student's name _____ DOB _____Grade_____
Allergy to: _____
Asthmatic? *Yes/No * Higher risk for severe reaction

Symptoms:
Mouth: Itching, tingling, or swelling of lips, tongue, mouth

Skin: Hives, itchy rash, swelling of the face or extremities

GI: Nausea, abdominal cramps, vomiting, diarrhea

Throat: Tightening of throat, hoarseness, hacking cough

Lung: Shortness of breath, repetitive coughing, wheezing

Heart: Weak or thready pulse, low blood pressure, fainting, pale, blueness

I request that my child be assisted by the nurse or **other trained staff members in taking the medications listed below. I understand that the Long Hill Township School District shall incur no liability as a result of any injury arising from my child being administered the medications as ordered by their physician as listed below. I shall hold harmless and indemnify the district and its employees against any claims arising from the administration of medication to my child.

_____ _____ _____/_____
Date Parent/guardian signature Home phone Work/cell#

CALL 911 –Must state that student is experiencing an allergic reaction.

Symptoms for which Epinephrine is to be given:_____
_____
Epinephrine: inject intramuscularly in outer thigh
(***circle one***) Epipen Epipen Jr. AUVI-Q 0.3mg AUVI-Q 0.15mg
May dose be repeated? _____ How soon?_____

Antihistamine: (Provide in a pre-measured dose if possible)**
Symptoms for which Antihistamine is to be given:_____
_____
Benadryl: Administer _____mg by mouth

Other: Medication_____ Dose _____ Route_____

_____ _____ _____
Date Physician's Signature/Stamp Phone Number

In the event that a nurse is not on site, other staff members have been trained to administer an Epipen, they are not allowed to administer any other medications.