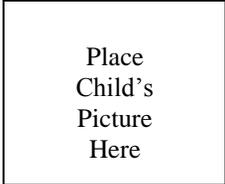


LEON COUNTY SCHOOLS

Individualized Student Allergy Action Plan for 20____-20____ School Year



Student Name: _____ DOB: _____

School: _____ Grade: _____ Teacher/Homeroom: _____

ALLERGY TO: _____

Asthma Diagnosis? Yes* No

*Higher risk for severe reaction

STEP 1: TREATMENT – This section to be completed by PHYSICIAN authorizing treatment

Symptoms:

Give Checked Medication:

- List of symptoms (Mouth, Skin, Gut, Throat, Lung, Heart, Other) and corresponding medication options (Epinephrine, Antihistamine) with checkboxes.

MEDICATION AND DOSAGE:

Epinephrine: Inject intramuscularly (circle one or list) EpiPen EpiPen Jr. Other: _____

Antihistamine: Give by mouth _____ medication/dose

Other: Give _____ medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed. EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR CALL 911!

2. Dr. _____ at _____

3. Emergency contacts: Name/Relationship Phone Numbers

1. _____ h _____ w _____ c _____

2. _____ h _____ w _____ c _____

3. _____ h _____ w _____ c _____

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____ (Required)

LOCATION OF INJECTABLE EPINEPHRINE: _____

Reviewed By LCHD School RN Signature: _____ Date: _____

IHP