

RIVER VALE SCHOOL DISTRICT

Allergy Action Plan

Student's

Name: _____ D.O.B. _____ Teacher : _____

ALLERGIC to: _____

Asthmatic: ☐ Yes* ☐ No *(Asthmatic student may be at higher risk for severe reaction)

Place

Child's

Picture

Here

< TREATMENT >

If an accidental ingestion is **SUSPECTED**, give:

∞**Benadryl** ☐ 12.5mg ☐ 25mg ☐ 50mg OR ∞**Zyrtec** ☐ 2.5mg ☐ 5mg ☐ 10mg

Observe closely for 30 minutes

IF ONE OR MORE ANAPHYLACTIC SYMPTOMS ARE OBSERVED:

Mouth	Itching, tingling or significant swelling of the lips, tongue or mouth
Skin	Hives, widespread redness, rash, swelling of the face or extremities
Gut	Nausea, abdominal cramps, repetitive vomiting, severe diarrhea
Throat	Tightening of throat, hoarseness, trouble breathing / swallowing, hacking cough
Lung	Shortness of breath, wheezing, repetitive cough
Heart	Pale, blue, faint, weak pulse, dizzy, thread pulse, low blood pressure

IMMEDIATELY GIVE:

- | | |
|--|--|
| ☐ EpiPen Jr. 0.15mg | ☐ EpiPen 0.30mg |
| ☐ Auvi-Q. 0.15mg | ☐ Auvi-Q 0.30mg |

CALL 911

- Report that an allergic reaction has been treated and that additional epinephrine may be needed.
- Lay person flat, raise legs and keep warm. Sit up if trouble breathing or vomiting.
- Alert emergency contacts.
- Transport to ER with copy of medical orders and EpiPen.

- ☐ Student has demonstrated understanding and ability to properly administer EpiPen and is authorized to carry and self-administer.

Additional directions: _____

Physician Signature _____

Address: _____

Phone Number: _____

Date: _____

Place Physician's Stamp Here

Emergency Contacts

Name	Relationship	Phone number	Cell Phone
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Authorization for Emergency Administration of Epinephrine by a Designated Individual

I hereby authorize the River Vale Board of Education to designate a nurse, or, in the absence of such, a trained designee to administer epinephrine to my child _____.
(Name of Child - Please Print)

Attached please find the written orders from my child's physician, Dr. _____,
Stating that my child requires the administration of Epinephrine for anaphylaxis and that he/she may or may not have the ability to self-administer.

I understand that if the procedures specified in NJSA 18A:40-12.5 are followed that the district shall have no liability as a result of any injury arising from the administration of a pre-filled, single dose, auto-injector mechanism containing epinephrine to the pupil and I shall indemnify and hold harmless the district and its employees.

Parent/Guardian Name (Please Print)

Parent/Guardian Signature

Date

Authorization for the Exchange of Confidential Medical Information

I hereby authorize an exchange of medical information as deemed necessary between the School Nurse and my child's physician.

Physician's Name: _____

Address: _____

Phone Number: _____

Parent/Guardian Name (Please Print)

Parent/Guardian Signature

Date