Medfield Afterschool Program

# *SEVERE ALLERGY ACTION PLAN*

Attach Photo

**USE THIS FORM FOR**: All severe allergies which require an antihistamine and/or an EpiPen. Please contact your child's program director to set up a time to review: allergy, forms, to provide training, and drop off required medication(s).

Name: _____ Grade: _____ Date of Birth: _____

Parent/Guardian: _____

Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

ALLERGY TO: _____

ASTHMATIC: ☐ Yes (Please attach a copy of your child's Asthma Action Plan - Higher risk for severe reaction)
☐ No

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG: Shortness of breath, repetitive coughing, wheezing
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN Many hives over body

Or combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (eyes, lips)
GUT: Vomiting, crampy pain

1. INJECT EPINEPHRINE IMMEDIATELY
2. CALL 9-911 (FROM MAP)
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/ bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis) USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around the mouth/face, mild itch
GUT: Mild nausea/discomfort

1. GIVE ANTIHISTAMINE
2. Stay with student; alert healthcare professional and parent
3. If symptoms progress (see above), USE EPINEPHRINE.
4. Begin monitoring (see box below)

MEDICATION: Epinephrine (brand): _____ (dose):_____

Antihistamine (brand): _____ (dose):_____

Other (inhaler-bronchodilator if asthmatic) (brand): _____ (dose):_____

What are the potential side effects of the treatment? _____

What are the potential consequences if treatment is not administered? _____

MONITORING – Stay with child; alert healthcare professionals & parent/guardian. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first symptoms persist or recur. For a severe reaction, consider keeping the child lying on back with legs raised. Treat student even if parent/guardian cannot be reached. See back/attached for auto-injection technique.

I, _____, the parent/guardian, will provide the MAP Staff with training that specifically addresses the child's allergy, medication(s), and other treatment needs.

I give permission for MAP to administer the above treatment, including the administration of the medications specified.

**Doctor's/Provider's Signature:** _____ **Date:** _____

**Print Name of Doctor/Provider:** _____ **Office Phone:** _____

**Parent's/Guardian's Signature:** _____ **Date:** _____

**Please complete second page & a Medication Consent Form (page 3) for *each* medication**

**EMERGENCY CONTACTS**

1. Name: _____Relation: _____
   Home Phone: _____ Work: _____ Cell: _____
2. Name: _____Relation: _____
   Home Phone: _____ Work: _____ Cell: _____
3. Name: _____Relation: _____
   Home Phone: _____ Work: _____ Cell: _____

## Allergy History and Program Considerations

Has your child ever needed to use an EpiPen or Inhaler? _____ How many times? _____

Last time used:_____ For What Symptoms: _____

Does your child need to ingest the allergen to have a reaction? _____

Does your child require special seating when having snack or lunch? _____

Will you be sending in special snacks? _____

Additional considerations MAP should be aware of: _____

_____

_____

_____

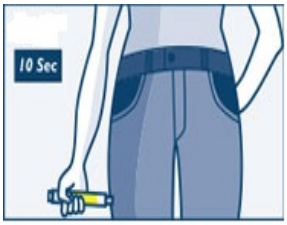
Does the child have the same medication, or other medications at school, that may be administered before they arrive at MAP and that would require the MAP staff to know when it was last taken? ____ **NO** ____ **YES** (if yes, answer the follow up question)

If yes, do you give your child's school nurse permission to contact MAP and/or for MAP to contact the nurse to see if any such medication was administered during the child's school day? ____ **NO** ____ **YES**

**Parent/Guardian Signature: _____ Date: _____**

### Directions for Giving Injection

- Remove EPIPEN Auto Injector from plastic carrying case.
- Pull off **BLUE** safety release cap.
- Swing and firmly push **ORANGE** tip against outer thigh so it **'clicks' AND HOLD** on thigh counting off approximately **10 seconds** to deliver the medication.
- Massage the injection area for 10 seconds.
- Document time administered.
- Put EPI Pen back in container and give to Emergency personnel to take with them to the Emergency Room.



Medfield Afterschool Program

# SEVERE ALLERGY ACTION PLAN
# MEDICATION CONSENT FORM

(only one medication per form)

To be filled out on the child's last day
Date returned:_____

Parent/Guardian Signature:

_____

## To be filled out by child's parent/guardian:

Name of Child: _____

Name of Medication:_____ (one medication per form) ☐ Prescription ☐ Non-Prescription

Type of Medication: ☐ EpiPen ☐ Liquid ☐ Pill (# Pills if prescription ____) ☐ Other _____

Storage Directions: _____

Dosage _____ (must match what the Licensed Health Care Practitioner authorized on the Individual Health Care Plan)

Date of 1st Dose _____ (MAP is not allowed to administer the 1st dose of a medication unless it is an emergency medication such as an EPI Pen)

- ☐ I have submitted to MAP their completed "Severe Allergy Action Plan" that was signed by the child's doctor and parent/guardian.
- ☐ I give permission to authorized MAP educators to administer medication to my child as indicated on the signed "Severe Allergy Action Plan".

**Parent/Guardian Signature: _____** **Date: _____**

## To be filled out by MAP Staff:

### Medication Administration Record

☐ Allergy Action Plan complete ☐ Original prescription label on the medicine container

☐ Name of the child on the container ☐ Date on prescription current ☐ Expiration Date _____

☐ Dose, name of drug, frequency of administration on the label consistent with instructions

**CHILD'S NAME: _____** **MEDICATION: _____**

| Date | Time | Medication | Dose | Route | Staff Signature | Miss dose Errors | Child Refusal (✓) |
|---|---|---|---|---|---|---|---|
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**If child refused medication, explain why and attach to administration record.*

*This record must be maintained in the child's file when complete*

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