DEPARTMENT OF HEALTH CITY OF NEW HAVEN

BUREAU OF NURSING

UNIVERSAL ALLERGY ACTION PLAN (AAP)

FOR STUDENTS REQUIRING MEDICATION

Student's Name : _____ DOB _____ GR _____

ALLERGY TO : _____

◆ STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication **:** ** To be determined by physician authorizing treatment	
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
▪ Lung †	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
▪ Heart †	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
▪ If a food allergen has been ingested, but *no symptoms*:		☐ Epinephrine	☐ Antihistamine
▪ Other †	_____	☐ Epinephrine	☐ Antihistamine
▪ If reaction is progressing (several of the above affected), give:		☐ Epinephrine	☐ Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen ® EpiPen ® Jr.

(see reverse side for instructions)

911 MUST BE CALLED IMMEDIATELY EpiPen ® IS ADMINISTERED !!

Antihistamine: give _____

medication / dose / route

Other: give _____

medication / dose / route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone _____

3. Parent _____ Phone _____

4. Emergency contacts:

Name / Relationship Phone Number (s)

a._____/_____ 1) _____ 2) _____

b._____/_____ 1) _____ 2) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY !

Parent/Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____

(Required)

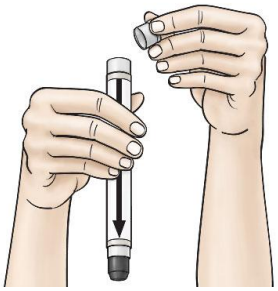
TRAINED STAFF MEMBERS

1. _____ Room _____

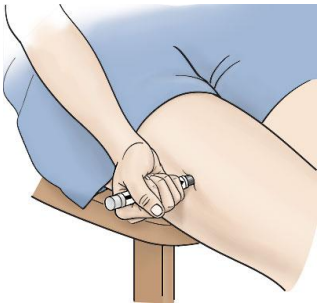
2. _____ Room _____

3. _____ Room _____

4. _____ Room _____



Pull off gray activation cap.



Hold black tip near outer thigh (always apply to thigh) swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Once EpiPen® is used, call 911. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

5/2009