



# Employee Allergy/Anaphylaxis Action Plan

Employee Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Supervisor \_\_\_\_\_

School Nurse \_\_\_\_\_ Phone Number \_\_\_\_\_

Health Care Provider \_\_\_\_\_ Preferred Hospital \_\_\_\_\_

History of Asthma  No  Yes-Higher risk for severe reaction

ALLERGY: (check appropriate) **To be completed by Health Care Provider**

- Foods (list):**
- Medications (list):**
- Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)**
- Stinging Insects (list):**

## RECOGNITION AND TREATMENT

Chart to be completed by Health Care Provider <i>ONLY</i>		Give CHECKED Medication	
<i>If food ingested or contact w/allergen occurs:</i>		Epinephrine	Antihistamine
No symptoms noted	<input type="checkbox"/> Observe for other symptoms		
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut+	Nausea, abdominal cramps, vomiting, diarrhea		
Throat+	Tightening of throat, hoarseness, hacking cough		
Lung+	Shortness of breath, repetitive coughing, wheezing		
Heart+	Thready pulse, low BP, fainting, pale, blueness		
Neuro+	Disorientation, dizziness, loss of consciousness		
If reaction is progressing (several of the above areas affected), <b>GIVE:</b>			
<b><i>The severity of symptoms can quickly change. + Potentially life-threatening</i></b>			

## DOSAGE:

**Epinephrine:** Inject into outer thigh  .3 mg

**Antihistamine: Liquid Diphenhydramine (Benadryl®)** \_\_\_\_\_ mg To be given by mouth *only if able to swallow.*

**Other:**

- This patient has received instruction in the proper use of the Auto-injector: EpiPen® or Twinject® (circle one).

**Health Care Provider Signature** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Date** \_\_\_\_\_

## EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call emergency contact(s) to notify of reaction, treatment and employee's health status.
3. Treat for shock. Prepare to do CPR.

**PREVENTION:** Avoidance of allergen is crucial to prevent anaphylaxis. Critical components to prevent life threatening reactions:  Indicates activity completed by facility staff

<input type="checkbox"/>	Encourage the use of Medic-Alert bracelets
<input type="checkbox"/>	Notify nurse and coworkers of known allergies
<input type="checkbox"/>	Use non-latex gloves and eliminate powdered latex gloves in schools
<input type="checkbox"/>	Post "Latex Reduced Environment" sign at entrance(s) of building
<input type="checkbox"/>	Encourage a no-peanut zone in the school cafeteria
<input type="checkbox"/>	Other:

**Side 2: To Be Completed by Employee and Supervisor**

**Allergy/Anaphylaxis Action Plan** (continued) **Employee Name** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**Employee AUTHORIZATIONS**

- I want this allergy plan implemented for myself; **I want to carry auto-injector** and I agree to release the school district and its personnel from all claims of liability if I suffer any adverse reactions from self-administration of epinephrine.
- It is recommended that backup medication be stored with the facility in case I forget or lose my auto-injector and/or antihistamine. The school district is not responsible or liable if backup medication is not provided to the facility and I am without working medication when medication is needed.

**Employee Affirmations**

- I have been trained in the use of my auto-injector and allergy medication and understand the signs and symptoms for which they are given;
- I agree to carry my auto-injector with me at all times;
- I will notify my supervisor **IMMEDIATELY** when auto-injector (epinephrine) is used;
- I will not share my medication with others or leave my auto-injector unattended;
- I will not use my allergy medications for any other use than what it is prescribed for.

**Your signature gives permission for a nurse to contact and receive additional information from your health care provider regarding the allergic condition(s) and the prescribed medication.**

**Employee Signature:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Back-up medication is stored at facility  Yes  No

**Approved by Supervisor Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**STAFF MEMBERS TRAINED**

NAME	TITLE	LOCATION/ROOM#	TRAINED BY

**EMERGENCY CONTACTS**

RELATIONSHIP	NAME	HOME#	WORK#	CELL#