Pittsburgh Public Schools
Expect great things.

REV 9-18

PITTSBURGH PUBLIC SCHOOLS – HEALTH SERVICES

ANAPHYLACTIC ALLERGY ACTION PLAN

Enter School Year _____ **Enter Current Date** _____

LAST NAME			DOB
FIRST NAME			GENDER
SCHOOL	GR	TEACHER	

ANAPHYLACTIC ALLERGY TO: _____

Y ☐	N ☐	Student is responsible to carry the EpiPen with them during the school day.
Y ☐	N ☐	The EpiPen will be kept with the nurse or office for immediate retrieval.

Medically necessary classroom or lunchroom accommodations? Yes ☐ or No ☐ If yes, please explain. _____

STEP 1: TREATMENT

Symptom: The severity of symptoms can quickly change.

	Give checked emergency medication or specify treatment	
If a food allergen has been ingested, but no symptoms	☐ EpiPen	☐ Benadryl
If stung by insect, with or without symptoms	☐ EpiPen	☐ Benadryl
Skin- Hives, itchy rash, swelling of face or extremities	☐ EpiPen	☐ Benadryl
Mouth- itching, tingling, or swelling of lips or tongue	☐ EpiPen	☐ Benadryl
Gut- Nausea, belly cramps, sudden vomiting or diarrhea	☐ EpiPen	☐
Throat- Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐
Lung- Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐
Heart- Thready pulse, fainting, pale, blueness, low BP	☐ EpiPen	☐
Other-	☐ EpiPen	☐

DOSAGE

Epinephrine: inject intramuscularly (check one) EpiPen ☐ or EpiPen Jr. ☐

This is an emergency medication and should be administered IMMEDIATELY BY STUDENT OR DESIGNATED SCHOOL STAFF.

Benadryl: give _____ tsp or _____ tab(s) by mouth if student is able to swallow.

Other: (Albuterol inhaler etc.) _____

These medications will be administered by the nurse or student. The nurse should be called to return to the building if not present.

STEP 2: CALL EMS if a severe allergic reaction is occurring or EpiPen is used.

1. Call 911, state that an allergic reaction has been treated, and additional support is needed.
2. Emergency Contacts: Call the parent/guardian to notify them of the incident.

Name & Relationship _____ Phone _____

Name & Relationship _____ Phone _____

I agree with the above plan, and agree that school health personnel and my child's physician or staff may discuss this plan if there are questions.

X _____ X _____ X _____

PARENT/GUARDIAN SIGNATURE PRINT NAME DATE

PHYSICIAN SIGNATURE _____ PHYSICIAN PRINT NAME _____

DATE _____ PHONE _____ FAX _____