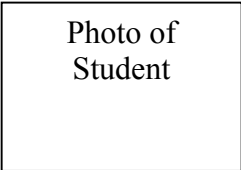


**Horace Mann Middle School**  
**Allergy Action Plan**  
Year \_\_\_\_\_



Dear Parent,

Your child has been noted to have a life threatening food, latex or stinging insect allergy that could require emergency treatment while at school. In order to insure the best possible treatment plan, we would like you to have your child's physician complete the bottom of this Allergy Action Plan. (If multiple severe allergies exist, please use one form for each allergy). **Please complete the back side of this form.**

Date \_\_\_\_\_

Student \_\_\_\_\_ Grade/Room \_\_\_\_/\_\_\_\_ Teacher \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone # \_\_\_\_\_

Additional Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

**Allergy** \_\_\_\_\_

Age when first reaction occurred \_\_\_\_\_ Date of most recent reaction \_\_\_\_\_

Describe Reaction (Hives, swelling, shortness of breath, wheezing, coughing, throat tightness, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**To be Completed by Physician**

MD's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
(please print)

(Child's Name) \_\_\_\_\_ has a severe allergy to \_\_\_\_\_  
\_\_\_\_\_ that may require emergency medical treatment.

Signs and symptoms of the allergy that should be watched for are: \_\_\_\_\_  
\_\_\_\_\_

**Please follow this Medication/Treatment Plan:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Further Instructions:

\_\_\_\_\_ MD Date \_\_\_\_\_  
Signature

\*Parent/Guardian, please complete back side of this form

To be completed by parent/guardian:

I have read and reviewed the above plan formulated by my child's physician and I agree that it may be on file, and shared with the appropriate staff, as part of my child's School Health Record.

**Allergy free table required for lunch**       Yes       No

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

New plan updates may be submitted throughout the school year with medication and/or treatment plan changes.

**Please note: Franklin Public School policy states that anyone requiring the use of an EpiPen will be transported by ambulance to the hospital. Emergency Medical Services are activated in the District by calling 911. In the case of an emergency, local EMS will transport to the nearest medical facility.**

### **EpiPen® and EpiPen Jr.®**



Follow these directions **only** when ready to use.

**Never put thumb, fingers, or hand over black tip.**

**Do NOT remove gray activation cap until ready to use.**

- 1) Familiarize yourself with the unit.
- 2) Grasp unit, with the black tip pointing downward.
- 3) Form a fist around the auto-injector (black tip down).
- 4) With your other hand, pull off the gray activation cap.
- 5) Hold black tip near outer thigh.
- 6) Swing and **jab firmly** into outer thigh so that auto-injector is perpendicular (at a 90° angle) to the thigh.
- 7) Hold **firmly in thigh** for **10** seconds.
- 8) Remove unit, massage injection area for several seconds.
- 9) Give used EpiPen to Emergency Medical Personnel.

**I have reviewed the above plan and have incorporated it in the student's School Health Record.**

\_\_\_\_\_  
RN

Date \_\_\_\_\_