Santa Cruz County Outdoor Science School
Allergy and Anaphylaxis Action Plan

To be completed by the child's physician if the student will bring an Epi-Pen to Outdoor Science School

Name of Student (Last)	(First)	Date of Birth
Parent/Guardian Name	Phone Number	School/Teacher

Allergen that may cause a severe reaction:_____

Note: In addition to this form, please complete the Physician and Parent Authorization to Administer Medication Form

If the student has these symptoms:	**Give this Medication (circle):**	
1. If a food allergen has been ingested or in the case of bee allergies, the student has been stung, but *no symptoms*	Epinephrine	Antihistamine
2. Mouth (itching, tingling, swelling of lips/tongue/mouth)	Epinephrine	Antihistamine
3. Skin (hives, itchy rash, swelling of face or extremities)	Epinephrine	Antihistamine
4. Gut (nausea, abdominal cramps, vomiting, diarrhea)	Epinephrine	Antihistamine
5. Throat (tightening, hoarseness, hacking cough)	Epinephrine	Antihistamine
6. Lungs (shortness of breath, repetitive coughing, wheezing)	Epinephrine	Antihistamine
7. Heart (thread pulse, low blood pressure, fainting, pale, blueness)	Epinephrine	Antihistamine
8. Other	Epinephrine	Antihistamine
9. If reaction is progressing (several of the above areas affected)	Epinephrine	Antihistamine

Medication Dosage:

Epinephrine auto injector: Inject into outer thigh 0.15mg OR 0.30mg

Antihistamine (medication/dose/route):

Other (medication/dose/route):

Give Medication then CALL:

1. Call 911 if epinephrine is given and/or symptoms are progressing to potentially life-threatening
2. Call the Outdoor Science School director on the two-way radio
3. Call parents/guardians

The child named above is under my care. It is necessary for him or her to receive the above prescribed medication while attending the Outdoor Science School. The medication may be administered by trained, nonmedical school employees, under the supervision of the health supervisor/EMT. The health supervisor/EMT may not be present during the administration of the medication.

Physician:_____ Phone Number:_____

Physician Signature:_____Date:_____