School Anaphylaxis Action Plan

**Include Child's photo*

Student Name: _____ Date of Birth: _____ Weight: _____ lbs Grade: _____

ALLERGY TO: _____

STEP 1: TREATMENT

SYMPTOMS: Give checked Medication as prescribed by physician authorizing treatment

If a food allergy has been ingested, [or bee sting] but ***no symptoms yet:*** Treat:		Epinephrine
MOUTH - Itching, tingling, or swelling of lips, tongue; mouth		Epinephrine
SKIN - Hives, itchy rash, swelling of the face or extremities		Epinephrine
GUT - Nausea, abdominal cramps, vomiting, diarrhea		Epinephrine
THROAT ***- Tightening of throat, hoarseness, hacking cough		Epinephrine
LUNG*** - Shortness of breath, repetitive coughing, wheezing		Epinephrine
HEART *** - Weak or thready pulse, low blood pressure, fainting, pale, blueness		Epinephrine
OTHER -		Epinephrine

***Potentially Life threatening. The severity of symptoms can quickly change**
IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis

PRESCRIBED DOSAGE

Epinephrine: Inject intramuscularly (**Check ONE**): **Junior Dose [0.15mg]** or **Regular Dose[0.30mg]**

SECOND DOSE: After 10 minutes, if emergency services have not arrived and symptoms persist, administer a 2nd dose.

Antihistamine or Asthma Inhalers: [Note to prescribing doctor: When a nurse is not always present to distinguish symptoms of anaphylaxis from other allergic reactions, pediatric allergists recommend that action plans be as simple as possible. When a nurse will not always be present, it is advised that antihistamines not be part of the action plan. Rather, auto-injectors and calling 911 for support should occur immediately.

Other Medication: Give _____

medication / dose / route / indications

Medical Provider's Signature _____ License # _____ Date: _____

School Nurse Signature _____ Date _____

Step 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number _____
3. Parent _____ Phone Number _____
4. Other Emergency Contacts:

Name / Relationship Phone Numbers

a. _____
b. _____
c. _____

I will notify the school immediately and submit a new form, if there are changes in the medication or dosage, time of administration, or a change in the prescribing physician. I give the school permission to contact the physician when necessary

Parents/Guardian Signature: _____ Date: _____