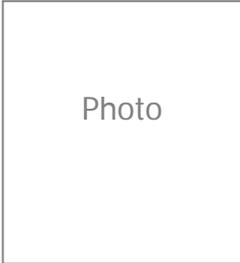


# Anaphylaxis Action Plan

For those requiring emergency EPINEPHRINE treatment  
"Anaphylaxis is a serious allergic reaction that is rapid in onset and may cause death."  
(National Institute of Allergy & Infectious Disease, 2010)



Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ALLERGIC to: \_\_\_\_\_

History of Asthma:  Yes (*more at risk for severe reaction*)  No

May self-carry medications:  Yes  No

May self administer medications:  Yes  No

### Medication Doses

#### EPINEPHRINE Dose:

**Up to 55 lbs.** (25 kg)

EpiPen Jr. (0.15 mg)

Adrenaclick (0.15 mg)

Twinject (0.15 mg)

**Over 55 lbs.** (25 kg)

EpiPen (0.3 mg)

Adrenaclick (0.3 mg)

Twinject (0.3 mg)

#### \*Antihistamine Type + Dose:

Benadryl (also known as Diphenhydramine)

12.5 mg (1 teaspoon or 1 chewable)

25 mg (2 teaspoons or 2 chewables)

50 mg (4 teaspoons or 4 chewables)

Other antihistamine: \_\_\_\_\_

Extremely reactive to the following foods: \_\_\_\_\_

#### THEREFORE:

If checked, give EPINEPHRINE immediately for ANY symptoms if the allergen was *likely* eaten.

If checked, give EPINEPHRINE immediately if the allergen was *definitely* eaten, even if no symptoms are noted.



#### Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

Lung: Short of breath, wheeze, repetitive cough

Heart: Pale, blue, faint, weak pulse, dizzy, confused

Throat: Tight, hoarse, trouble breathing/swallowing

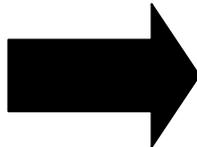
Mouth: Obstructive swelling (tongue and/or lips)

Skin: Many hives over body

Or **combination** of symptoms from different body areas:

Skin: Hives, itchy rashes, swelling (eyes, lips)

Gut: Vomiting, crampy pain



#### 1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911

3. Begin monitoring (as specified below)

4. Give additional medications:\*

- Antihistamine
- Inhaler (bronchodilator) if asthma

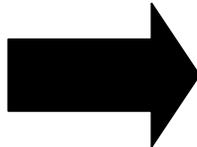
\*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat severe reaction (anaphylaxis). USE EPINEPHRINE.

#### MILD SYMPTOMS only:

Mouth: Itchy Mouth

Skin: A few hives around mouth/face, mild itch

Gut: Mild nausea/discomfort



#### 1. GIVE ANTIHISTAMINE

2. Stay with student; alert healthcare professionals and parent/guardian

3. If symptoms progress (see above) USE EPINEPHRINE

4. Begin monitoring (as specified below)

For unique situations: \_\_\_\_\_

### Monitoring

A **SECOND DOSE** of EPINEPHRINE can be given 5 minutes or more after the first if symptoms persist or recur.

**Stay with person; alert healthcare professionals and parent/guardian.** Tell rescue squad EPINEPHRINE was given. Note time when EPINEPHRINE was administered. For a severe reaction, consider keeping person lying on back with legs raised. Treat person even if parents cannot be reached. See back/attached for auto-injection technique.

Provider Signature: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

Printed Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

## Edina Public Schools Anaphylaxis Action Plan

(This page to be completed by parent/guardian)

Student's Name: \_\_\_\_\_ School: \_\_\_\_\_

School Year: \_\_\_\_\_

### **Parent/Guardian Authorization**

1. I agree with the above Anaphylaxis Action Plan and I request that the above medication/s be given during school hours as ordered by my child's physician/licensed prescriber.
2. I request that the above medication be sent on field trips.  Yes  No
3. I will notify the school if medication is stopped.
4. I give permission for the medication/s to be given by school personnel as delegated, trained, and supervised by the licensed school nurse.
5. Legally I may refuse to sign the Anaphylaxis Action Plan. If I refuse to sign, the district will not be able to administer the prescribed medication.
6. This consent may be revoked at any time by sending a written notice to the licensed school nurse.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

### **Permission for Release of Information**

1. I give permission for the school nurse to communicate, as needed with school staff about my child's medical condition/s and the action of the medication/s.
2. I give permission for the licensed school nurse to contact my child's physician/licensed prescriber regarding questions about the above listed medication/s or medical condition/s being treated by medication/s. If I do not give permission, the district may not be able to administer medication.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

Licensed School Nurse \_\_\_\_\_ Date \_\_\_\_\_

Health Associate \_\_\_\_\_ Date \_\_\_\_\_

For Licensed School Nurse Use

Trained personnel delegated to administer Epi-Pen/Auvi-Q

1. \_\_\_\_\_ Date: \_\_\_\_\_
2. \_\_\_\_\_ Date: \_\_\_\_\_