

INDIVIDUAL EMERGENCY HEALTH PLAN FOR ANAPHYLAXIS for \_\_\_\_/\_\_\_\_ School Year

(Anaphylaxis is a potentially life-threatening allergic reaction. Act quickly.)



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Doctor: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

**DELEGATES TRAINED IN THE USE OF EPINEPHRINE AUTO-INJECTORS:**

- Asthmatic** (Check if YES - Student has higher risk of a severe allergic reaction. Epinephrine should be given first (before asthma medications) in case of a reaction with any breathing symptoms.  
**ALLERGEN(S):** \_\_\_\_\_

**Medications & Dosages:** \_\_\_\_\_ **Child's Weight:** \_\_\_\_\_ lbs.

**Epinephrine Auto-Injector, Jr.** 0.15 mg intramuscularly prn anaphylaxis & call 911. May repeat once as indicated below if symptoms do not improve within 20 minutes of 1<sup>st</sup> dose or return of symptoms.

**Epinephrine Auto-Injector** 0.3 mg intramuscularly prn anaphylaxis & call 911. May repeat once as indicated below if symptoms do not improve within 20 minutes of 1<sup>st</sup> dose or return of symptoms.

**Benadryl** \_\_\_\_mg. po q 4-6 hrs prn allergic reaction.

**Other antihistamine:** \_\_\_\_\_ mg. po q \_\_\_\_ hrs prn allergic reaction.

<u>CAUTION</u>	<u>Epinephrine</u>	<u>Epinephrine 2<sup>nd</sup> Dose</u>	<u>Antihistamine</u>
No symptoms and <i>suspected</i> ingestion of allergen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No symptoms and <i>known</i> ingestion of allergen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose/Eyes: Hayfever-like symptoms: runny, itchy Nose, red eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin (1): Localized hives and/or localized itchy rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>EMERGENCY</u>	<u>Epinephrine</u>	<u>Epinephrine 2<sup>nd</sup> Dose</u>	<u>Antihistamine</u>
Mouth: Itching, tingling or swelling of lips, tongue or mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin (2): Hives and/or itchy rash on more than one part of the Body, swelling of face or extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gut: Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat: Hacking cough, tightening of throat, hoarseness, Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung: Shortness of breath, wheezing, short, frequent, Shallow cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart: Weak pulse, low blood pressure, fainting, dizzy, Pale, cyanotic (blueness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Multiple:</b> Symptoms from 2 or more of the above categories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**For Minors Only:**

- This student is capable and has been instructed in the proper method of self-administration of the Epinephrine Auto-injector in accordance with New Jersey Law.
- This student is NOT approved to self-medicate.
- This student MAY CARRY the Epinephrine Auto-injector.
- This student MAY NOT CARRY the Epinephrine Auto-injector.

\_\_\_\_\_  
 School, Middlesex Regional Educational Services Commission, the Diocese of Metuchen (where applicable) and their employees/agents are not liable for any complications arising from the administration of the Epinephrine Auto-injector or other medication.

This student is my patient and I have ordered the above treatment plan.

I authorize the administration of above for my child, to be followed by transportation to \_\_\_\_\_ (or nearest) Hospital if Epinephrine is given.

Physician Signature & Stamp (Below) \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_