

Emergency Action Plan – Anaphylaxis

Student Name _____ DOB _____
Team/Academy _____ ID# _____
Parent/Guardian Name _____ Phone _____
Parent/Guardian Name _____ Phone _____
Emergency Contact Name _____ Phone _____
Primary Care Provider _____ Phone _____
Allergic to _____

Medication Prescribed

Epinephrine: Inject intramuscularly per manufacturer instructions (circle one) :
Twinject 0.3 mg Twinject 0.15 mg Epipen Epipen, Jr

Other: _____

If above named students exhibits symptoms of anaphylaxis in response to allergen exposure, administer prescribed medication and call 911 immediately.

If new symptoms have appeared or symptoms have not improved within about 10 minutes of the first dose, a second dose of epinephrine is needed.

Symptoms of Anaphylaxis

Mouth	Itching, tingling or swelling of lips, tongue, mouth
Skin	Hives, itchy rash, swelling of the face or extremities
Gut	Nausea, abdominal cramps, vomiting, diarrhea
Throat	Tightening of throat, hoarseness, hacking cough, drooling,
Lung	Shortness of breath, repetitive cough, wheezing
Heart	Thready pulse, low blood pressure, fainting, pale, blueness
Other	_____

The severity of symptoms can change quickly.

Additional Instructions _____

Health Care Provider Signature _____ Date _____

Parent Signature _____ Date _____

Health Care Provider Signature and Parent Signature required on both sides of form.

U.S.D. # 475
Secondary (Grades 6-12) Anaphylaxis Medication Self- Carry Permission Form

MUST COMPLETE BOTH SIDES OF FORM

Student Name _____ Grade _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

The above named student has been instructed in and understands the proper use of his/her auto-injectable epinephrine. He/she understands the purpose, appropriate method, and the indications for use of the auto-injectable epinephrine.

Health Care Provider Signature _____ Date _____

TO BE COMPLETED BY PARENT/GUARDIAN

I grant permission for my child to carry and self-administer his/her auto-injectable epinephrine as prescribed. I will have on file with the school nurse a prescriber completed and signed emergency anaphylaxis action plan prior to my child being allowed to carry and self-administer his/her auto-injectable epinephrine.

I also acknowledge that USD #475 and its officers, employees or agents incur no liability for damage, injury or death resulting directly or indirectly from the self-administration of medication and agreeing to release, indemnify and hold USD #475 and its officers, employees and agents, harmless from and against any claims relating to the self administration of auto-injectable epinephrine. I hereby authorize a USD #475 school nurse to exchange information with the prescriber and with the pharmacy identified on the affixed pharmacy label.

Parent/Guardian Signature _____ Date _____

FOR SCHOOL USE ONLY
Contract Between Student and School Nurse to Carry
Auto-Injectable Epinephrine

1. Student has demonstrated correct use of an auto-injectable epinephrine demonstrator.
2. Student agrees to never give the auto-injectable epinephrine pen to another person.
3. Student agrees to insure that the school nurse is notified immediately if he/she uses the auto-injectable epinephrine.
4. Student agrees to have the auto-injectable epinephrine identified with his/her name on it.

Student Signature _____ Date _____

School Nurse Signature _____ Date _____

Health Care Provider Signature and Parent Signature required on both sides of form.