# Simi Valley Unified School District

Student Support Services 875 E. Cochran St. Simi Valley, CA 93065 805-306-4500

## ALLERGY/ANAPHYLAXIS EMERGENCY PLAN

Name: ______________________________ DOB ____________ School ________________

Allergy to: ______________________________________ Asthma: ☐ Yes ☐ No

**MILD SYMPTOMS ONLY:**

| | |
|---|---|
| MOUTH: | Itchy mouth |
| NOSE: | Itchy/runny nose, sneezing |
| SKIN: | A few hives around mouth/face, mild itch |
| GUT: | Mild nausea/discomfort |

1. GIVE ANTIHISTIMINE
2. Stay with student and monitor.
3. Contact parent and school nurse.
4. If symptoms progress (see below), USE EPINEPHRINE

**Extremely reactive to the following foods/allergens:** ______________________________

**THEREFORE:**

☐ If checked, give epinephrine immediately for ANY symptoms after ***likely*** exposure to allergen.

☐ If checked, give epinephrine immediately if student has ***definite*** exposure to allergen, even if no immediate symptoms are noted.

**Any SEVERE SYMPTOMS after suspected or known ingestion/exposure:**

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, diarrhea, crampy pain |

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Monitor breathing and airway
4. Administer antihistamine/inhaler, after epinephrine, if prescribed below.
5. Lay student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
6. Give second dose of epinephrine if symptoms persist or recur (5 minutes or more after last dose) if prescribed.
7. Contact parent and school nurse.

### Medications/Doses

Antihistamine (brand and dose): ______________________________

Epinephrine (brand and dose): ______________________________

☐ Administer 2nd dose of epinephrine ______ minutes after 1st dose if symptoms persist or recur.

Other (e.g., inhaler-bronchodilator, if asthmatic): ______________________________

**Parent Consent for Authorization and Management of Anaphylaxis in School Setting**

I (we) the undersigned, the parent(s)/guardian(s) of the above named student, request that the specialized physical healthcare service, anaphylaxis treatment, be administered to my (our) child in accordance with state laws and regulations.

I(we) give consent for the school nurse to communicate with the authorized healthcare provider.

Parent(s)/Guardian(s) Signature: ______________________________ Date: ____________

Physician Signature: ______________________________ Date: ____________

Name: ________________ Address: ______________________ Phone: ____________

*Rev. 05/15 AA, BA*