COUNCIL ROCK SCHOOL DISTRICT
Anaphylaxis Action Plan/Emergency Care Plan

Name_____ **Date of Birth:**_____

Allergy To: _____

Asthmatic: *____Yes____No * Higher Risk for Severe Reaction

♦ **STEP 1: TREATMENT** ♦

*** SYMPTOMS *** **Give Circled Medication****

SYSTEMS	SYMPTOMS		
Mouth	Itching, tingling or swelling of lips, tongue, mouth	Epinephrine	Antihistamine
Throat*	Itching, tightness of throat, hoarseness, hacking cough	Epinephrine	Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	Epinephrine	Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine
Lung*	Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
Heart*	"Thready" pulse, low BP, fainting, pale, blueness	Epinephrine	Antihistamine
Other	_____	Epinephrine	Antihistamine
If reaction is progressing (several above areas affected) give		Epinephrine	Antihistamine

The severity of symptoms can quickly change. *Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Auvi-Q™ 0.3 mg Auvi-Q™ 0.15 mg

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

Health Care Provider Signature_____**Date**_____

♦ **STEP 2: EMERGENCY CALLS** ♦

1. Call 911 (or Rescue Squad :_____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ at _____
3. Emergency contacts:

Name/Relationship	Phone Number(s)
• _____	1)_____2)_____
• _____	1)_____2)_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY

☐ Both the medical provider and the parent feel that the child may carry and self-administer their EpiPen

☐ The student will demonstrate administration skills to the school nurse and that they are capable of responsible behavior in the administration of the medication

Health Care Provider Printed Name _____ **Phone:**_____

Health Care Provider Signature _____ **Date:**_____

I request that my child be allowed to carry his/her medication in accordance with school board medication policy and be responsible for its proper storage and use.

YES NO My child requires special seating in the cafeteria

Parent Signature _____ **Date**_____