ANAPHYLAXIS ACTION PLAN

Student Photo Here

Student Name _____ Birthdate _____ Grade _____

To be completed by a practitioner:

Allergic to _____

Asthma □ Yes □ No

Effective Date: School Year 20 _____ - _____ (including summer school, if applicable)

For ANY of the following SEVERE SYMPTOMS:

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: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, diarrhea, cramps

*Severity of symptoms can change quickly. *Some symptoms can be life-threatening. ACT FAST!*

1. **INJECT EPINEPHRINE IMMEDIATELY!**
Medication:
_____
Dose: _____
2. **Call 911.** Note time epinephrine was given.
3. Keep student calm and seated.
4. Monitor student's condition and provide first aid if necessary.
5. **If symptoms don't improve within _____ minutes, give second dose of epinephrine (if available.)**
6. Additional medicine (if any):
Medication: _____
Dose: _____

For MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

IF MORE THAN ONE MILD SYMPTOM, GIVE EPINEPHRINE.

1. **Administer antihistamine***
Medication_____
Dose_____
2. Additional medicine if any:
Medication _____
Dose_____
3. Stay with student and monitor symptoms.
4. **If symptoms don't improve or get worse move on to Severe Symptom treatment.**
5. Call parent and School Nurse

*Antihistamines such as loratadine, fexofenadine, and cetirizine are not considered fast-acting medications and are not appropriate for early treatment of possible anaphylaxis.

□ **YES** □ **NO** Student understands anaphylaxis AND has successfully demonstrated epinephrine delivery. Student *may* self-carry epinephrine device while at school and during school sponsored events.

ALL STUDENT'S EMERGENCY MEDICATIONS MUST BE EASILY ACCESSIBLE AT ALL TIMES.
EMERGENCY MEDICATIONS MUST ACCOMPANY STUDENT ON ALL TRIPS AWAY FROM THE BUILDING.

To be completed by parent/guardian:

□ **YES** □ **NO** My student needs to sit at an allergy aware table for lunch.
□ **YES** □ **NO** Contact me for directions on special occasion treats; I will also supply a safe snack box.
□ **YES** □ **NO** My student may eat treats with wording such as "may contain, processed in a facility or made on shared equipment."

PARENT/GUARDIAN SIGNATURE _____ Phone _____ Date _____

I hereby give permission to staff designated by the school principal or nurse to give the above medication to my student according to the instructions stated above and authorize them to contact the practitioner, if necessary.

PRACTITIONER SIGNATURE _____ Phone _____ Date _____

Practitioner signature directs the above medication administration and indicates willingness to communicate with school staff regarding this medication.