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:_____

Place Picture Here

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 1st 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 1st dose or return of symptoms.

☐ **Benadryl** ____mg. po q 4-6 hrs prn allergic reaction.

OR

☐ **Other antihistamine:**_____ ___mg. po q___ hrs prn allergic reaction.

CAUTION	Epinephrine	Epinephrine 2nd Dose	Antihistamine
No symptoms and *suspected* ingestion of allergen	☐	☐	☐
No symptoms and *known* ingestion of allergen	☐	☐	☐
Nose/Eyes: Hayfever-like symptoms: runny, itchy Nose, red eyes	☐	☐	☐
Skin (1): Localized hives and/or localized itchy rash	☐	☐	☐

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

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.

_____

Physician Signature & Stamp (Below) Date

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

_____

Parent/Guardian Signature Date