

SCHOOL DISTRICT 25 ANAPHYLAXIS ACTION PLAN

Name: _____ Age/ DOB: _____ DATE: _____

Allergy : Peanut Insect Sting Shellfish Latex Medication Other _____

History of anaphylaxis: Yes No High Risk for sever reaction: Yes No History of asthma Yes No

Other health problems besides anaphylaxis: _____

Other currently used medications: _____

- Signs & Symptoms** May appear anxious or express a sense of impending doom
- MOUTH: Itching, swelling of lips and/or tongue
 - NOSE/EYES: Runny, itchy nose, or sneezing
 - THROAT: Itching, difficulty swallowing, hoarseness, tightness/closure
 - SKIN: Flushing, rash, hives, swelling of face
 - GUT: Abdominal cramps, nausea, vomiting, diarrhea
 - LUNG: Shortness of breath, wheezing, cough, increased respirations
 - HEART: Weak pulse, low blood pressure, dizzy, passing out, loss of consciousness

ADMINISTER EPINEPHRINE IMMEDIATELY if **two or more** of the above symptoms of suspected anaphylaxis are present or **one** symptom after a known allergen exposure.

EPHINEPHRINE IS THE FIRST LINE OF TREATMENT!

What to do in order of importance:

1. Inject Auto-Injectable Epinephrine in thigh
 - EpiPen Jr. (0.15 mg) EpiPen (0.3mg)
 - Other Auto-Injectable Epinephrine _____
2. Call 911 or Rescue Squad
3. Observe for signs of improvement. If no improvement in 10-15 minutes, give 2nd dose of epinephrine.
4. Additional Medications to be given: _____

Emergency Contact #1	_____	_____	_____
	Name	Phone	Relationship
Emergency Contact #2	_____	_____	_____
	Name	Phone	Relationship

Additional Comments: _____

EVENT REPORT – Please complete and send with patient to emergency department.

Time of 1st dose _____ Time of 2nd dose _____

Signature of person giving injection/treatment: _____ Date _____

School Signature Date

Parent Signature Date