Baldwin Union Free School District

Anaphylaxis Emergency Action Plan

Patient Name_____ Age: _____

Allergies: _____

Asthma: ☐ Yes (high risk for severe reaction) ☐ No

Additional health problems besides anaphylaxis: _____

_____

Concurrent Medications: _____

_____

Symptoms of Anaphylaxis

MOUTH	itching, swelling of lips and/or tongue
THROAT*	itching, tightness/closure, hoarseness
SKIN	itching, hives, redness, swelling
GUT	vomiting, diarrhea, cramps
LUNG*	shortness of breath
HEART*	weak pulse, dizziness, passing out

Only a few symptoms may be present Severity of symptoms can change quickly.

*Some symptoms can be life-threatening. ACT FAST!

Emergency Actions Steps – Do NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):

☐Adrenaclick (0.15 mg) ☐Adrenaclick (0.3 mg)

☐Auvi-Q (0.15 mg) ☐Auvi-Q (0.3 mg)

☐EpiPen Jr (0.15mg) ☐EpiPen (0.3 mg)

Epinephrine Injection, USP Auto-injector-authorized generic

☐ (0.15 mg) ☐ (0.3 mg)

☐ Other (0.15 mg) ☐ (0.3 mg)

Specify others: Administer EpiPen after 10 minutes if patient is still symptomatic.

IMPORTANT: **ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS**

2. Call 911 or rescue squad (before calling contact)

3. Emergency contact #1: Home_____ Work_____ Cell_____
   Emergency contact #2: Home_____ Work_____ Cell_____
   Emergency contact #3: Home_____ Work_____ Cell_____

Comments: _____

_____.

_____

Doctor's Signature/Date/Phone Number

_____

Parent's Signature (for individuals under age 18 yrs.) Date

BALDWIN UNION FREE SCHOOL DISTRICT
AUTHORIZATION OF MEDICATION ADMINISTRATION IN SCHOOL

Dear Parent/Guardian:

Please complete this form when a prescription or non-prescription medication is required to be administered in school. We will need:

- A written order from your doctor.
- A parent signature authorizing the Health Office to give the medication.

A parent or guardian must deliver the medication to the nurse in the prescription bottle or original store packaging. UNLABELED MEDICATION WILL NOT BE ACCEPTED OR ADMINISTERED. It is the responsibility of the parent or guardian to keep count of the amount of medication sent into the school.

PHYSICIAN ORDER

NAME OF STUDENT: _____ DIAGNOSIS: _____

MEDICATION: _____ DOSAGE: _____ FREQUENCY: _____

SELF DIRECTED AND/OR MAY ADMINISTER OWN MEDICATION ON SCHOOL TRIPS: YES _____ NO _____

MD SIGNATURE: _____ DATE: _____ PHYSICIAN STAMP:

PARENT GUARDIAN CONSENT:
Check the appropriate box(es) below:

☐ Please administer the above-mentioned medication as per physician's order.

☐ Please allow my child to self-administer his/her own medication on class trip.

☐ Please allow my child to carry his/her INHALER/EPI PEN. He or she has been instructed on usage and understands the purpose, method and frequency for this medication.

Parent/Guardian Name: _____ Signature: _____ Date: _____

PLEASE NOTE

Students are only allowed to carry inhalers and/or EpiPens while in school. All other medications need to be stored in the Health Office.

*****This information must be updated annually*****