ALLERGY AND ANAPHYLAXIS EMERGENCY CARE PLAN

HEALTH SERVICES
SCHOOL DISTRICT U-46

Student Name_____ School Year_____

Date of Birth_____ Teacher/Grade _____

Child is allergic to _____

Child's Picture Here

Child Has Asthma ☐ Yes ☐ No
Child Has Had Anaphylaxis ☐ Yes ☐ No
Child May Self- Carry Medicine ☐ Yes ☐ No
Child May Self Administer ☐ Yes ☐ No

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION/STING:

LUNG: shortness of breath, wheeze, coughing
HEART: pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)
SKIN: Many hives all over body

Or Combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

~Call 911
~Begin Monitoring (see below)
~Additional Medications:
~Antihistamine
~Inhaler (bronchodilator) if Asthma

*Inhalers/bronchodilators and antihistamines are not to be depended on to treat a severe reaction (anaphylaxis)→Use Epinephrine.

**When in doubt, use Epinephrine. Symptoms can rapidly become more severe.

MILD SYMPTOMS ONLY

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort

GIVE ANTIHISTAMINE

~ Stay with child, alert health care professionals and parent

IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

☐ **SPECIAL SITUATION:** If this box is checked, child has an EXTREMELY severe allergy to insect sting or the following food(s):_____. Even if the child has MILD symptoms after a sting or eating these foods, **give epinephrine**

MEDICATIONS/DOSES (Medication permission forms needed for each medication)

EPINEPHRINE (BRAND/DOSE): _____

ANTIHISTAMINE (BRAND/DOSE): _____

Other (e.g. Inhaler/Bronchodilator if asthma: _____

MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first dose if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

_____ _____ _____
Physician Signature (REQUIRED) Date Phone Number

_____ _____ _____
Parent/Guardian Signature Date Phone Number