HEALTH SERVICES

School Year _____
School _____
Grade _____
Student ID # _____

ALLERGY AND ANAPHYLAXIS EMERGENCY ACTION PLAN

Student Name:_____ Date of Birth: _____ Weight: _____
Emergency Contact #1: _____ Preferred Contact #: _____
Emergency Contact #1: _____ Preferred Contact #: _____
Physician that Treats Allergy: _____ Physician's Contact #: _____
Preferred Hospital: _____

Allergic to: _____
Asthma: ☐ YES ☐ NO (If yes, higher chance of severe reaction)
Has had anaphylaxis in the past: ☐ YES ☐ NO If yes, date of last reaction: _____
Extremely reactive to the following allergen(s): _____

This section and below is to be completed by the Physician

☐ If checked, give **epinephrine IMMEDIATELY** for **ANY** symptoms if **LIKELY** had contact with the allergen.

☐ If checked, give **epinephrine IMMEDIATELY** for **DEFINITE** contact with the allergen, **even if no symptoms** are present.

WHAT TO LOOK FOR

ANY OF THE FOLLOWING **SEVERE** SYMPTOMS:

- **LUNG** - Shortness of breath, wheezing, repetitive cough
- **HEART** - Skin color is pale or bluish, weak pulse, dizziness or fainting
- **THROAT** - Tight or hoarse throat, trouble breathing or swallowing
- **MOUTH** - Swelling of lips or tongue that bothers breathing
- **SKIN** - Many hives over body, widespread redness
- **GUT** - Repetitive vomiting or severe diarrhea
- **OTHER** - Feeling like something bad is going to happen (doom), confusion, or agitation
- **OR a combination of symptoms** from different body systems

WHAT TO DO

1. Immediately give epinephrine
2. Call 911 (tell dispatch the person is having anaphylaxis and what time epinephrine was given)
3. Stay with the student and
   a. Lay them flat on their back with legs raised
   b. If vomiting or having trouble breathing, let them sit up or lay them on their side
   c. Give a second dose of epinephrine if symptoms get worse, continue, or do not get better in 5 minutes
   d. Notify emergency contacts
4. Give other medicine if prescribed. Do not use another medicine in place of epinephrine.
   a. Antihistamine
   b. Inhaler (bronchodilator) if wheezing

WHAT TO LOOK FOR

ANY OF THE FOLLOWING **MILD** SYMPTOMS:

- Itchy or runny nose, sneezing
- Itchy mouth
- A few hives, mild itch
- Mild nausea or stomach discomfort

For **MILD SYMPTOMS** from **MORE THAN ONE** different body system, **GIVE EPINEPHRINE**

WHAT TO DO

1. Stay with the student and
   a. Watch them closely for changes
   b. Give antihistamine (if prescribed)
   c. Notify emergency contact

MEDICATION TYPE	MEDICATION NAME	DOSAGE	ROUTE	SELF-CARRY/ADMINISTER
Epinephrine				☐ YES ☐ NO (epinephrine only)
Antihistamine				N/A
Other (bronchodilator, etc)				☐ YES ☐ NO (inhaler only)

Physician Signature_____ Physician Printed Name_____ Date_____

AUTHORIZATION: Parent/legal guardian authorizes Keller ISD staff to administer treatment and medications specified according to the instructions above, gives permission to Keller ISD staff to contact the Physician for additional information, if needed, and acknowledges they must provide ordered medications to the school.

Parent/Legal Guardian Signature_____ Parent/Legal Guardian Name_____ Date_____

Form adapted from FARE and AAP

School Year _____
School _____
Grade _____
Student ID # _____

Student Name: _____ **Date of Birth:** _____
Allergic to: _____

Additional Information:

EPINEPHRINE AND STAFF INFORMATION		
Epinephrine storage location		
Trained staff name / location		
Trained staff name / location		
Buddy Nurse name / location		
Other		

Acknowledged and received by:

RN Name: _____ Signature: _____ Date: _____

RN/LVN Name: _____ Signature: _____ Date: _____

☐ Allergy EAP electronically sent via Laserfiche to all staff directly involved with student services. RN Initials _____ Date _____