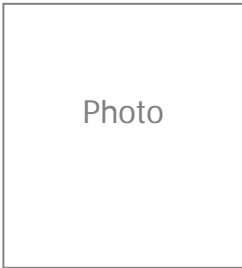


Anaphylaxis Action Plan

For those requiring emergency EPINEPHRINE treatment
"Anaphylaxis is a serious allergic reaction that is rapid in onset and may cause death."
(National Institute of Allergy & Infectious Disease, 2010)



Name: _____ DOB: _____

ALLERGIC to: _____

History of Asthma: Yes (*more at risk for severe reaction*) No

May self-carry medications: Yes No

May self administer medications: Yes No

Medication Doses

EPINEPHRINE Dose:

- | | |
|--|---|
| Up to 55 lbs. (25 kg) | Over 55 lbs. (25 kg) |
| <input type="checkbox"/> EpiPen Jr. (0.15 mg) | <input type="checkbox"/> EpiPen (0.3 mg) |
| <input type="checkbox"/> Adrenaclick (0.15 mg) | <input type="checkbox"/> Adrenaclick (0.3 mg) |
| <input type="checkbox"/> Twinject (0.15 mg) | <input type="checkbox"/> Twinject (0.3 mg) |

*Antihistamine Type + Dose:

- Benadryl (also known as Diphenhydramine)
- 12.5 mg (1 teaspoon or 1 chewable)
- 25 mg (2 teaspoons or 2 chewables)
- 50 mg (4 teaspoons or 4 chewables)
- Other antihistamine: _____

Extremely reactive to the following foods: _____
THEREFORE:
 If checked, give EPINEPHRINE immediately for ANY symptoms if the allergen was *likely* eaten.
 If checked, give EPINEPHRINE immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

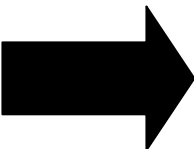
Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

Lung: Short of breath, wheeze, repetitive cough
Heart: Pale, blue, faint, weak pulse, dizzy, confused
Throat: Tight, hoarse, trouble breathing/swallowing
Mouth: Obstructive swelling (tongue and/or lips)
Skin: Many hives over body

Or **combination** of symptoms from different body areas:

Skin: Hives, itchy rashes, swelling (eyes, lips)
Gut: Vomiting, crampy pain



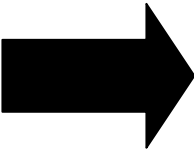
1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (as specified below)
4. Give additional medications: *

- Antihistamine
- Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS only:

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



1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent/guardian
3. If symptoms progress (see above) USE EPINEPHRINE
4. Begin monitoring (as specified below)

For unique situations: _____

Monitoring

A **SECOND DOSE** of EPINEPHRINE can be given 5 minutes or more after the first if symptoms persist or recur.

Stay with person; alert healthcare professionals and parent/guardian. Tell rescue squad EPINEPHRINE was given. Note time when EPINEPHRINE was administered. For a severe reaction, consider keeping person lying on back with legs raised. Treat person even if parents cannot be reached. See back/attached for auto-injection technique.

Provider Signature: _____ Phone _____ Date _____

Printed Name: _____

Parent/Guardian Signature: _____ Phone _____ Date _____

2014-2015 Edina Public Schools • Anaphylaxis Action Plan
This page to be completed by parent/guardian

Student's Name: _____ **School:** _____

Parent/Guardian Authorization

1. I agree with the above Anaphylaxis Action Plan and I request that the above medication/s be given during school hours as ordered by my child's physician/licensed prescriber.
2. I request that the above medication be sent on field trips. Yes No
3. I will notify the school if medication is stopped.
4. I give permission for the medication/s to be given by school personnel as delegated, trained, and supervised by the licensed school nurse.
5. Legally I may refuse to sign the Anaphylaxis Action Plan. If I refuse to sign, the district will not be able to administer the prescribed medication.
6. This consent may be revoked at any time by sending a written notice to the licensed school nurse.

Parent/Guardian Signature

Date

Permission for Release of Information

1. I give permission for the school nurse to communicate, as needed with school staff about my child's medical condition/s and the action of the medication/s.
2. I give permission for the licensed school nurse to contact my child's physician/licensed prescriber regarding questions about the above listed medication/s or medical condition/s being treated by medication/s. If I do not give permission, the district may not be able to administer medication.

Parent/Guardian Signature

Date

Licensed School Nurse _____ Date _____

Health Associate _____ Date _____

For Licensed School Nurse Use

Trained personnel delegated to administer Epi-Pen/Auvi-Q

1. _____ Date: _____

2. _____ Date: _____