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)

Photo

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)
- ☐ EpiPen Jr. (0.15 mg)
- ☐ Adrenaclick (0.15 mg)
- ☐ Twinject (0.15 mg)

Over 55 lbs. (25 kg)
- ☐ EpiPen (0.3 mg)
- ☐ Adrenaclick (0.3 mg)
- ☐ 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*

Children's Physician Network
An affiliate of Children's Hospitals and Clinics of Minnesota
www.clinics4kids.org

Turn Form Over →

Adapted from the Food Allergy & Anaphylaxis Network (FAAN) Action Plan
www.foodallergy.org

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: _____

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