Place child's picture here

School Anaphylaxis Action Plan

Student's Name: _____ Date of Birth: _____ Weight: _____lbs.

ALLERGY TO: _____

STEP 1: TREATMENT

	Symptoms:		Give Checked Medication as prescribed by physician authorizing treatment	
	If a food allergen has been ingested, [or bee sting] but ***no symptoms yet***: Treat:			Epinephrine
•	Mouth	Itching, tingling, or swelling of lips, tongue, mouth		Epinephrine
•	Skin	Hives, itchy rash, swelling of the face or extremities		Epinephrine
•	Gut	Nausea, abdominal cramps, vomiting, diarrhea		Epinephrine
•	Throat †	Tightening of throat, hoarseness, hacking cough		Epinephrine
•	Lung †	Shortness of breath, repetitive coughing, wheezing		Epinephrine
•	Heart †	Weak or thready pulse, low blood pressure, fainting, pale, blueness		Epinephrine
•	Other			Epinephrine

† Potentially life-threatening. The severity of symptoms can quickly change.
IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis

PRESCRIBED DOSAGE

Epinephrine: inject intramuscularly **(Check ONE): Junior Dose [0.15mg]** or **Regular Dose [0.30mg]**

SECOND DOSE: After 10 minutes, if emergency services have not arrived and symptoms persist, administer 2nd dose.

Antihistamine or Asthma Inhalers: [Note to prescribing doctor: *When a nurse is not always present to distinguish symptoms of anaphylaxis from other allergic reactions, pediatric allergists recommend that action plans be as simple as possible. When a nurse will not always be present, it is advised that antihistamines not be part of the action plan. Rather, auto-injectors and calling 911 for support should occur immediately.*]

Other Medication: Give: _____
medication / dose / route / indications

Medical Provider's Signature _____ License # _____ Date _____

School Nurse Signature _____ Date _____

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed
2. Dr. _____ Phone Number: _____
3. Parent: _____ Phone Number(s): _____
4. Other emergency contacts:

Name / Relation	Phone Number(s):
a. _____	_____
b. _____	_____
c. _____	_____

I will notify the school immediately and submit a new form, if there are changes in the medication or dosage, time of administration, or a change in the prescribing physician. I give school permission to contact the physician when necessary.

Parent/Guardian's Signature _____

Date _____

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