ANAPHYLAXIS ACTION PLAN
To be completed by physician

Place Photo Here

NAME: _____Birthdate: _____

Allergic To:_____

Weight: _____lbs. History of Asthma: Yes ☐ (*more risk for severe reaction) No☐
Student may self-carry/self-administer medications: Yes ☐ No ☐

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.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

_____ _____ _____ _____
Physician Signature Date Name (Printed) Phone

_____ _____
Parent Signature Date

Parent/Guardian (Authorization and Disclaimer): Per my signature above, I request that the school assist my child with the above medications in accordance with state laws and regulations. Should the doctor determine that my child is competent to carry and self administer above medications I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self administration of above medications. I authorize staff to communicate with the physician regarding my child's medical condition and/or the medications prescribed for it. ***I have read and agree with the information provided above. I understand and give my consent for this information to be shared with school, transportation, and emergency personnel as deemed necessary to provide quality of care. This consent is valid for one year from date unless otherwise stated and may be revoked at any time.** Adapted from FARE Food Allergy & Anapphylaxis Emergency Care Plan www.foodallergy.org 5/15

Roseville High School District
School Health Care Plan for Students with Severe Allergies
Student Demographic Information and Health History
(This portion to be completed by parent)

Last Name:_____ **First Name:**_____

Date of Birth (mm/dd/yyyy):_____School:_____Teacher/Grade:_____

Parent/Guardian Name:_____Parent/Guardian Phone #:_____

Other Emergency Contact:_____Other Emergency Phone #:_____

Health Care Provider Name:_____Health Care Provider Phone #:_____

SEVERELY ALLERGIC TO:_____

History of Allergic Reactions

What was the allergen:_____Total reactions:_____

Treatment provided:_____Date of last reaction:_____

Other medical information (check if applicable): ❑ Asthma ❑ Inhaler at school ❑ Medical ID worn

How soon after contact does your child react? _____ minutes_____ hours_____ days

Please indicate symptoms that your child has experienced with previous reactions (mark all that apply):

☐All over tingling or itching	☐Vomiting, stomach cramping or diarrhea
☐All over rash or hives	☐Wheezing or difficulty breathing
☐Coughing or sneezing	☐Blue or gray discoloration of lips or fingernails
☐Sudden mood change	☐Dizziness or fainting
☐Red face	☐Seizures
☐Tightness of throat and/or chest	☐Loss of consciousness
☐Swelling of eyes, lips, tongue, throat or neck	☐Other_____

What are the early warning signs that indicate your child is starting to have an allergic reaction?

Does he or she recognize these warning signs? ☐Yes ☐No

Does your child know how to avoid known allergens (causes of allergic reactions)? ☐Yes ☐No

Please mark what your child does to prevent or avoid an allergic reaction:

- ☐ Knows what to avoid (list:_____).
- ☐ Tells others about his or her allergies
- ☐ Tells an adult **immediately** if exposed to an allergen
- ☐ Asks about ingredients in foods, if unsure about contents
- ☐Firmly refuses food that might be a problem food

I do not want my student to have medication to treat this reaction at school. I understand the risks this presents for my student. If the need to have medication at school changes I will notify the nurse and obtain a completed medication at school form from the physician as soon as possible _____. Initial s

Form completed by _____Relationship to cild_____

Parent Signature _____Date_____

Parent/Guardian (Authorization and Disclaimer): Per my signature above, I request that the school assist my child with the medications included the Anaphylaxis Action Plan in accordance with state laws and regulations. Should the doctor determine that my child is competent to carry and self administer above medications I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self administration of above medications. I authorize staff to communicate with the physician regarding my child's medical condition and/or the medications prescribed for it. ***I have read and agree with the information provided above. I understand and give my consent for this information to be shared with school, transportation, and emergency personnel as deemed necessary to provide quality of care. This consent is valid for one year from date unless otherwise stated and may be revoked at any time.**

(To be completed by school nurse)

Location of emergency medications:_____

*School Nurse signature:*_____ *Date*