

# ANAPHYLAXIS ACTION PLAN

Student Photo Here

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_

To be completed by a practitioner:

Allergic to \_\_\_\_\_

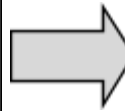
Asthma  Yes  No

Effective Date: School Year 20 \_\_\_\_\_ - \_\_\_\_\_ (including summer school, if applicable)

## For ANY of the following **SEVERE** SYMPTOMS:

**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:** Hives, itchy rashes, swelling (e.g., eyes, lips)  
**GUT:** Vomiting, diarrhea, cramps

*Severity of symptoms can change quickly. \*Some symptoms can be life-threatening. ACT FAST!*



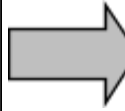
## 1. INJECT EPINEPHRINE IMMEDIATELY!

Medication: \_\_\_\_\_  
Dose: \_\_\_\_\_  
2. **Call 911.** Note time epinephrine was given.  
3. Keep student calm and seated.  
4. Monitor student's condition and provide first aid if necessary.  
5. **If symptoms don't improve within \_\_\_\_\_ minutes, give second dose of epinephrine (if available.)**  
6. Additional medicine (if any):  
Medication: \_\_\_\_\_  
Dose: \_\_\_\_\_

## For MILD SYMPTOMS ONLY:

**MOUTH:** Itchy mouth  
**SKIN:** A few hives around mouth/face, mild itch  
**GUT:** Mild nausea/discomfort

**IF MORE THAN ONE MILD SYMPTOM, GIVE EPINEPHRINE.**



## 1. Administer antihistamine\*

Medication \_\_\_\_\_  
Dose \_\_\_\_\_  
2. Additional medicine if any:  
Medication \_\_\_\_\_  
Dose \_\_\_\_\_  
3. Stay with student and monitor symptoms.  
4. **If symptoms don't improve or get worse move on to Severe Symptom treatment.**  
5. Call parent and School Nurse

\*Antihistamines such as loratadine, fexofenadine, and cetirizine are not considered fast-acting medications and are not appropriate for early treatment of possible anaphylaxis.

**YES**  **NO** Student understands anaphylaxis AND has successfully demonstrated epinephrine delivery. Student *may* self-carry epinephrine device while at school and during school sponsored events.

**ALL STUDENT'S EMERGENCY MEDICATIONS MUST BE EASILY ACCESSIBLE AT ALL TIMES.  
EMERGENCY MEDICATIONS MUST ACCOMPANY STUDENT ON ALL TRIPS AWAY FROM THE BUILDING.**

To be completed by parent/guardian:

- YES**  **NO** My student needs to sit at an allergy aware table for lunch.  
 **YES**  **NO** Contact me for directions on special occasion treats; I will also supply a safe snack box.  
 **YES**  **NO** My student *may* eat treats with wording such as "may contain, processed in a facility or made on shared equipment."

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

I hereby give permission to staff designated by the school principal or nurse to give the above medication to my student according to the instructions stated above and authorize them to contact the practitioner, if necessary.

**PRACTITIONER SIGNATURE** \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

practitioner signature directs the above medication administration and indicates willingness to communicate with school staff regarding this medication.