EMERGENCY ACTION PLAN

Anaphylaxis – Life-Threatening Allergies

Student Name: _____ DOB: _____ Grade: _____

Identified Allergen(s): _____

Asthma: ❑ Yes ❑ No Other relevant health concerns: _____

Student Picture

Contact Information:

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Additional Contacts: _____ Phone: _____

Building Health Office/School Nurse: _____ Phone: _____

IMPORTANT: EACH ALLERGIC REACTION MAY INCREASE IN SEVERITY FROM PREVIOUS REACTIONS.
ALLERGIC REACTIONS CAN INCREASE IN SEVERITY QUICKLY – PROVIDE EMERGENCY CARE AS QUICKLY AS POSSIBLE

A LIFE-THREATENING ALLERGIC REACTION MAY INCLUDE ANY OR ALL OF THESE SYMPTOMS:

Are any of these signs and symptoms present and severe?

✓ 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 over body

Or is there a combination of symptoms from different body areas?

✓ SKIN: Hives, itchy rashes, swelling (eyes, lips)
✓ GUT: Vomiting, cramping pain, diarrhea
✓ RESPIRATORY: Runny nose, sneezing, swollen eyes, phlegmy throat
✓ OTHER: Confusion, agitation, feeling of impending doom

DO THIS

Initiate care – do not delay treatment if anaphylaxis is suspected. When in doubt, give epinephrine.

TREATMENT: Epinephrine – Medication is at school ❑ Yes ❑ No Dosage: _____

Directions for administration: _____ ❑ Repeat dose after 5 or more minutes if needed

❑ Treatment should be initiated immediately following exposure without waiting for symptoms (per healthcare provider)

❑ Treatment should be initiated only following the appearance of symptoms (per healthcare provider)

THEN MONITOR

PROVIDE ONGOING CARE: Stay with the student, maintain airway, do not have the student rise to an upright position. Observe for changes.

If epinephrine is given, 911 should be called immediately and the student should be transported to the nearest emergency room. Preferred hospital: _____

Doctor's Name: _____ Date: _____

Emergency Plan written by: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The parent/guardian signature authorizes the nurse to share this information with school staff on a "need to know" basis. In the event of an emergency, care will be initiated and parents will be contacted.

This plan is in effect for the current school year only.