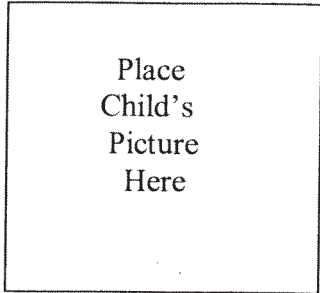


**ROXBURY TOWNSHIP PUBLIC SCHOOLS  
Anaphylaxis Action Plan**



Student's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Teacher: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Asthmatic Yes\*  No  \*Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

<u>Symptoms:</u>	<u>Give Checked Medication**:</u> **(To be determined by physician authorizing treatment)
• If a food allergen has been ingested, but <i>no symptoms</i> :	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Mouth      Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Skin      Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Gut      Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Throat+      Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Lung+      Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Heart+      Weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Other+      _____	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• If reaction is progressing (several of the above areas affected), give	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine

+ Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE - Numerically state the order in which these medications are to be administered.

\_\_\_\_\_ **Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15mg  
\*A trained delegate may only administer epinephrine, therefore if an antihistamine and epinephrine are ordered, the delegate may skip the antihistamine and administer epinephrine immediately for symptoms.

\*A trained delegate **may not** administer a 2<sup>nd</sup> dose of epinephrine.

\_\_\_\_\_ Repeat X \_\_\_\_\_ in \_\_\_\_\_ minutes.

\_\_\_\_\_ **Antihistamine:** give \_\_\_\_\_  
medication/dose/route

\_\_\_\_\_ **Other:** give \_\_\_\_\_  
medication/dose/route

SELF-ADMINISTRATION\*

[ ] This student has been trained and is **capable of self-administration** of the following medication(s)

- Epinephrine – single dose unit
- Epinephrine & antihistamine – single dose units

\*Under NJ state law, orders for antihistamines alone cannot be self-administered.

[ ] This student is **NOT capable of self-administration** of the medications named above.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Telephone \_\_\_\_\_

Physician's Providers Stamp:

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Parent \_\_\_\_\_ Phone Number(s) cell \_\_\_\_\_  
work \_\_\_\_\_  
home \_\_\_\_\_  
Parent \_\_\_\_\_ Phone Number(s) cell \_\_\_\_\_  
work \_\_\_\_\_  
home \_\_\_\_\_

**IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR HAVE CHILD TRANSPORTED VIA RESCUE SQUAD TO NEAREST EMERGENCY MEDICAL FACILITY!**

I verify that my child \_\_\_\_\_ has a potentially life threatening illness **and has been instructed in self-administration** of the prescribed medication in a life threatening situation. **I hereby give my permission for my child to self-administer prescribed medication.** I further acknowledge that the Roxbury Township School District shall incur no liability as a result of any injury arising from the self-administration of medication by my child, if procedures specified by NJ law and Roxbury Township School District policy are followed. I shall indemnify and hold harmless the Roxbury Township School District and it's employees or agents against any claims arising out of administration of medication to my child.

I give permission for a trained delegate, if available, to administer prescribed epinephrine to my child in the absence of the nurse.

\_\_\_\_\_  
PARENT/GUARDIAN PRINTED NAME

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE