ANAPHYLAXIS ACTION PLAN

Name of Student: _____

D.O.B.: _____ Sex: _____ Grade/Teacher: _____

ALLERGY TO: _____

ASTHMATIC: [ ] Yes^ [ ] No (^*Higher Risk for Severe Reaction*)

Place Child's Picture Here

STEP 1: TREATMENT

SYMPTOMS:

GIVE CHECKED MEDICATION^^:
(^^*To be determined by physician authorizing treatment*)

a.	If a food allergen has been ingested, but ***no symptoms***	a. [ ] Epinephrine	[ ] Antihistamine
b.	Mouth — Itching, tingling, or swelling of lips, tongue, mouth	b. [ ] Epinephrine	[ ] Antihistamine
c.	Skin — Hives, itchy rash, swelling of the face or extremities	c. [ ] Epinephrine	[ ] Antihistamine
d.	Gut — Nausea, abdominal cramps, vomiting, diarrhea	d. [ ] Epinephrine	[ ] Antihistamine
e.	Throat + — Tightening of throat, hoarseness, hacking cough	e. [ ] Epinephrine	[ ] Antihistamine
f.	Lung + — Shortness of breath, repetitive coughing, wheezing	f. [ ] Epinephrine	[ ] Antihistamine
g.	Heart + — Weak or thready pulse, low blood pressure, fainting, pale, blueness	g. [ ] Epinephrine	[ ] Antihistamine
h.	Other + _____	h. [ ] Epinephrine	[ ] Antihistamine
i.	If reaction is progressing (several of the above areas affected), give:	i. [ ] Epinephrine	[ ] Antihistamine

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

DOSAGE: Numerically state the order in which the medications are to be administered:

_____ **EPINEPHRINE:** inject intramuscularly: (circle one): EpiPen Jr® 0.15mg | EpiPen® 0.3mg | Auvi-Q 0.15mg | Auvi-Q 0.3mg

- 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 2nd dose of epinephrine.
- Repeat X _____ in _____ minutes.

_____ **ANTIHISTAMINE:** give _____
medication/dose/route

_____ **OTHER:** give _____
medication/dose/route

SELF-ADMINISTRATION:** (***Under NJ State Law, orders for antihistamines alone cannot be self-administered.*)

[ ] 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

[ ] 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:**

Name:		
Cell:	Work:	Home:

PARENT:

Name:		
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!

STEP 3: PARENT/GUARDIAN CONSENT & RELEASE

BY SIGNING BELOW:

- I verity 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 its employees or agents against any claims arising out of administration of medication to my child.
- **I hereby give permission for a trained delegate, if available, to administer prescribed epinephrine to my child in the absence of the nurse.**
- **I hereby give consent for the disclosure of the information contained in the Anaphylaxis Action Plan to all staff who may be involved in the implementation of the plan and to other appropriate staff.**

_____	_____	_____
Parent/Guardian Printed Name	Parent/Guardian Signature	Date