Individual Emergency Health Plan for Anaphylaxis

Call 911 when Epinephrine has been administered.

PICTURE OF STUDENT

Name:_____ Allergic to: _____
D/O/B: _____ _____
Weight: _____ _____
Teacher / Class: _____

☐ **Asthmatic** *(Check box if YES)* Student has an increased risk of a severe allergic reaction. Epinephrine should be given first (before asthma medications) in case of a reaction with any breathing symptoms.

« STEP 1 TREATMENT »

SIGNS OF AN ALLERGIC REACTION		**MEDICATION** (indicate medication name/dose/route, to be determined by physician authorizing treatment)	
Category	**Symptom(s)**	**Epinephrine**	**Antihistamine**
	No symptoms and *suspected* ingestion of allergen.	First Dose ☐ Second Dose ☐	Yes ☐ No ☐
	No symptoms and *known* ingestion of allergen.	First Dose ☐ Second Dose ☐	Yes ☐ No ☐
Mouth	Itching, tingling, or swelling of lips, tongue, or mouth	First Dose ☐ Second Dose ☐	Yes ☐ No ☐
Nose/Eyes	Hay fever-like symptoms: runny, itchy nose; red eyes	First Dose ☐ Second Dose ☐	Yes ☐ No ☐
Skin(1)	Localized hives and/or localized itchy rash	First Dose ☐ Second Dose ☐	Yes ☐ No ☐
Skin(2)	Hives and/or itchy rash on more than one part of the body, swelling of face or extremities	First Dose ☐ Second Dose ☐	Yes ☐ No ☐
Gut	Nausea, abdominal cramps, vomiting, diarrhea	First Dose ☐ Second Dose ☐	Yes ☐ No ☐
Throat	Hacking cough, tightening of throat, hoarseness, difficulty swallowing	First Dose ☐ Second Dose ☐	Yes ☐ No ☐
Lung	Shortness of breath; wheezing; short, frequent, shallow cough	First Dose ☐ Second Dose ☐	Yes ☐ No ☐
Heart	Weak pulse, low blood pressure, fainting, dizzy, pale, cyanosis (blueness)	First Dose ☐ Second Dose ☐	Yes ☐ No ☐
Multiple	Symptoms from two or more of the above categories.	First Dose ☐ Second Dose ☐	Yes ☐ No ☐

DOSAGE

Epinephrine: **Brand Name: _____** **Dosage:** ( ) 0.15 mg IM ( ) 0.3 mg IM

Antihistamine Medication: **Brand Name: _____** **Dosage: _____**

Inhaler-Bronchodilator **Brand Name: _____** **Dosage: _____**

Student may self-carry epinephrine: Yes ____ No _____ Student may self-administer epinephrine: Yes ____ No ____

« After administering treatment, turn page over for EMERGENCY CONTACTS »

« 2. EMERGENCY CONTACTS »

	NAME	RELATIONSHIP	PHONE NUMBER	INSTRUCTIONS
1	**911**			- 911 is the <u>first</u> call that must be made after administering epinephrine. - Indicate to the first responders that the student is suffering from an allergic reaction and may require additional epinephrine.
2	**Physician:** Dr._____	Student's allergist or pediatrician		
3	**Parent/Guardian:**	(Specify Relationship):		
4	**Parent/Guardian:**	(Specify Relationship):		
5	**Emergency Contact** (name):	(Specify Relationship):		
6	**If Possible - What hospital would you like the child transported to in case of an allergic reaction?**			

Administration of Epinephrine

Date: _____

Dosage: _____

Time: _____

Who administered the epinephrine?

_____

The forenamed student is my patient and I have authorized the treatment protocol outlined on the preceding page and affirm that there are no contraindications to receiving the treatment protocol.

Physician signature and date:_____

I authorize the administration of epinephrine, antihistamine or other specified medication to the forenamed student as per the treatment protocol outlined on the preceding page.

Parent/Guardian signature and date:_____