ANAPHYLAXIS ACTION PLAN
To be completed by physician

NAME: _____ Birthdate: _____

Allergic To: _____

Weight: _____ lbs. History of Asthma: Yes ☐ (*more risk for severe reaction) No ☐

Student may self-carry/self-administer medications: Yes ☐ No ☐

Extremely reactive to the following foods: _____

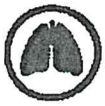
THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - Antihistamine
  - Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., Inhaler-bronchodilator if wheezing): _____

_____

As the prescribing physician, in the event there is no school nurse or other licensed person to administer medication, I authorize a trained unlicensed assistive person/trained health care aid to administer this prescribed medication to the above student.

Physician Signature	Date	Name (Printed)	Phone
_____	_____	_____	_____

PLACER

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ALLERGY/ANAPHYLAXIS ACTION PLAN

Student Name: _____

Parent Consent and Authorization

I (we), the undersigned, the parent(s)/guardians of the above named student, request my (our) student be assisted with or administered the following medication in accordance with the California Education Code. I agree to:

1. Provide all medications, supplies, and equipment.
2. Notify the school if there is a change in the student's health or attending physician.
3. Notify the school immediately and provide a new consent for any changes in the doctor's orders.
4. I acknowledge that if my student carries and administers their own medication it is my responsibility to ensure they have it prior to any field trips.

I authorize the school to communicate with the above health care practitioner when necessary in regards to this specific medication and medical condition.

Parent/Guardian Signature _____ Date _____

Nurse's Signature _____ Date _____