VA Planning District 16 School Health T.E.A.M

Severe Allergy/Anaphylaxis Action Plan and Treatment Authorization

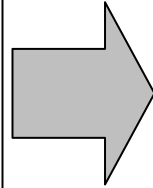
Child's Photograph

Name:______________________________________ DOB_____________________
Teacher:_____________________________________ Grade:___________________
Allergy to:____

Asthma: Yes:______ No:_______ (higher risk for a severe reaction)

Weight:_______lbs __________kg

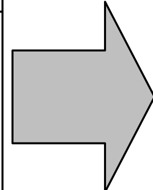
RECOGNIZE SEVERE ANAPHYLAXIS SYMPTOMS:
LUNG: shortness of breath, wheezing, repetitive cough
Heart: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: tight, hoarse, trouble breathing/swallowing,
MOUTH: Swelling of the throat, lips, tongue, metallic taste
SKIN: generalized flushing or itching, hives (rash), swelling
GUT: Vomiting, cramps, diarrhea, nausea
Any **ONE**or **COMBINATION** of the above symptoms from different body areas can progress rapidly to a life threatening situation!!



INJECT EPINEPHRINE IMMEDIATELY!!
1. Call 911
2. Begin Monitoring
3. Administer Rescue Inhaler if asthmatic
4. Give additional medications

****Inhalers/Bronchodilators and antihistamines are NOT to be depended on to treat a severe reaction (anaphylaxis).**
USE EPINEPHRINE!

MILD SYMPTOMS ONLY:
MOUTH: Itching *without* swelling, especially seen with ingestion of fresh fruits
SKIN: Limited redness of skin/few small hives



1. Give Antihistamine
2. Stay with student, call parents
3. If symptoms progress, **USE EPINEPHRINE**
4. Begin Monitoring

______ If checked, administer epinephrine for **ANY** symptoms if there was **possible** exposure
______ If checked, administer epinephrine **BEFORE** symptoms occur, if there was **known** exposure

MEDICATIONS/DOSES:
EPINEPHRINE AUTO-INJECTOR: (BRAND AND DOSE): EpiPen_______ EpiPen JR______ Auvi-Q______ Auvi-Q JR______
BRONCHODILATOR: (BRAND AND DOSE): ____
ANTIHISTAMINE: (BRAND AND DOSE): ____
(*** Antihistamines should NOT be used as a first line of treatment during an anaphylaxis episode. It will treat itching ONLY – it will not halt vascular collapse or swelling!!)

MONITORING: Stay with student. Alert Health Care professionals and parent. Tell rescue squad epinephrine was given and request an ambulance with epinephrine. Note time when epinephrine was administered. **A second dose of epinephrine can be administered within 5 minutes** if symptoms persist or recur. For a severe reaction consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.

___ Student may carry epinephrine ___ Student may *self-administer* epinephrine
___ *Classroom accommodations needed

EMERGENCY CONTACTS: 911 **Rescue Squad:__________________________**
Parent/Guardian:________________________ Phone:______________________________
Name/Relationship:______________________ Phone:______________________________

LICENSED HEALTH CARE PROVIDER (signature):____ Date:_____________
Printed name of Health Care Provider: ____ Phone:________________

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in providing emergency medical treatment consistent with this plan, including the administration of medication to my child. I understand the Virginia School Health Guidelines , Code of Virginia, 8.01-225 Protects school staff members from liability arising from actions consistent with this plan. I also hereby authorize the school district staff to disclose my child's protected health information to chaperones, and other non-employee volunteers at the school or school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Guardian Signature: ____ Date:________________