

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 <i>suspected</i> ingestion of allergen.	First Dose <input type="checkbox"/> Second Dose <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	No symptoms and <i>known</i> ingestion of allergen.	First Dose <input type="checkbox"/> Second Dose <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Mouth</i>	Itching, tingling, or swelling of lips, tongue, or mouth	First Dose <input type="checkbox"/> Second Dose <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Nose/Eyes</i>	Hay fever-like symptoms: runny, itchy nose; red eyes	First Dose <input type="checkbox"/> Second Dose <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Skin(1)</i>	Localized hives and/or localized itchy rash	First Dose <input type="checkbox"/> Second Dose <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Skin(2)</i>	Hives and/or itchy rash on more than one part of the body, swelling of face or extremities	First Dose <input type="checkbox"/> Second Dose <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Gut</i>	Nausea, abdominal cramps, vomiting, diarrhea	First Dose <input type="checkbox"/> Second Dose <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Throat</i>	Hacking cough, tightening of throat, hoarseness, difficulty swallowing	First Dose <input type="checkbox"/> Second Dose <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Lung</i>	Shortness of breath; wheezing; short, frequent, shallow cough	First Dose <input type="checkbox"/> Second Dose <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Heart</i>	Weak pulse, low blood pressure, fainting, dizzy, pale, cyanosis (blueness)	First Dose <input type="checkbox"/> Second Dose <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Multiple</i>	Symptoms from two or more of the above categories.	First Dose <input type="checkbox"/> Second Dose <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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: _____

Who administered the epinephrine?

Dosage: _____

Time: _____

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: _____