GISD Anaphylaxis Emergency Action Plan School Year:_____
(To be completed by Physician)

Name_____ DOB_____ Grade_____ Ride Bus: ☐ Y ☐ N
(If Epi-pen is necessary for transportation a 2nd set must be provided)

ALLERGY TO: _____

Asthmatic? ☐ Yes* ☐ No * higher risk for severe reaction

Step1: Treatment

	Symptoms:	**Give Checked Medication: (To be determined by the physician**	
If a food allergen has been ingested but ***no symptoms:*** ☐ Observe		☐ Epinephrine	☐ Antihistamine
Mouth	Itching, tingling or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
Throat*	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
Lung*	Shortness of breath, repetitive cough, wheezing	☐ Epinephrine	☐ Antihistamine
Heart*	Weak, thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other*	_____	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affected), give:		☐ Epinephrine	☐ Antihistamine

***Potentially life threatening. The severity of the symptoms can change quickly.**
Monitor for side effects of epinephrine injection: nervousness, palpitations, fast heart rate, sweating, tremor, anxiety, dizziness, headache, nausea, vomiting, or weakness.

DOSAGE:

Epinephrine: inject intramuscularly ☐ EpiPen® ☐ Epipen Jr. ®
☐ Twinject™ 0.3 mg ☐ Twinject™ 0.15 mg
☐ AvuiQ 0.3 mg ☐ AvuiQ 0.15 mg

☐ Give second epinephrine dose after _____ minutes if no improvement and EMS has not arrived.

Antihistamine: Give: _____ Other: _____
(Medication / dose / route) (Medication / dose / route)

Step 2: Emergency Contacts

1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Emergency Contacts:

	Name	Phone #	Relationship
a.	_____	_____	_____
b.	_____	_____	_____
c.	_____	_____	_____

_____ / _____ _____ / _____
Physician/Healthcare Provider Signature Date Parent/Guardian Signature Date

I give my child permission to carry his/her epinephrine auto-injector and self administer. _____ (Initials)
(Parent see reverse side)

Student Information Sheet

(To be completed by parent)

Student Name: _____ Date of Birth: _____ Date: _____

Allergy to: _____

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction? ___Yes ___ No

How many times has your student had a reaction? ____Never ____Once ____ More than once

Explain: _____

When was the last reaction? _____

Are the reactions: ____Staying the same ____Getting Worse ____Getting Better

How quickly do the signs and symptoms appear? ____ Seconds ____Minutes ____ Hours

What are the signs and symptoms of your student's allergic reaction? _____
(Be specific; include things the student might say?

Nurse Checklist

(To be completed by School Nurse)

When a student with a life-threatening allergy is *****identified, this checklist must be completed by the school RN and placed with the student's health card. A copy is also placed in the confidential folder for that student each school year, and must be dated / renewed each year.
(*****identification includes any statements made on the health card that state "anaphylactic allergies and the use of an Epi-Pen.)

Date Done:

_____ Parent contacted.
_____ Student's entered into TeXIS with "health alert".
_____ Emergency Health Care Plan received.
_____ Student's teachers and administrators notified.
_____ Transportation director and campus food manager notified.
_____ Student brought to health room to meet nurse, see where supplies are kept.
_____ Medication labeled, expiration dates checked, and medication kept in an accessible unlocked area.
_____ Substitute folder includes info regarding students with Anaphylaxis.

Additional Nurse Notes:
_____
_____

School Nurse Signature…… Date……..