

**WASHINGTON TOWNSHIP PUBLIC SCHOOLS
Gloucester County, NJ**

**LIFE-THREATENING ALLERGY (ANAPHYLAXIS)
ACTION PLAN**

Student Name: _____ D.O.B. _____ Grade: _____

ALLERGY TO: _____

Asthmatic Yes No *Higher risk for severe reaction

Place
Child's
Picture
Here

◆ **STEP 1: TREATMENT** ◆

Symptoms	Give Checked Medication <small>(To be determined by physician authorizing treatment)</small>
• If exposure to allergen, but no symptoms:	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Mouth Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Skin Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Gut Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Throat † Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Lung † Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Heart † Weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Other †	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• If reaction is progressing in several of the above areas DO NOT HESITATE TO GIVE:	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: Inject intramuscularly (circle one) EpiPen® EpiPen® Jr.

Antihistamine: Give: _____ Dose _____ Route _____

Other: Give _____ Dose _____ Route _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ **STEP 2: EMERGENCY CALLS** ◆

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Physician: _____ Office Number: _____

3. Parents/Guardian: _____ Home: _____

Mother Cell: _____ Mother Work: _____

Father Cell: _____ Father Work: _____

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE
OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian's Signature _____ Date: _____

Doctor's Signature _____ Date _____

Physician's Office Stamp:

*COMPLETE BOTH SIDES**

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**LIFE THREATENING ALLERGY (ANAPHYLAXIS)
HEALTH CARE PROVIDER ORDERS / EMERGENCY CARE PLAN – Part 2**

Individual Considerations:

Bus – Transportation should be alerted to student’s allergy Date _____

- This student **MUST** carry EpiPen on bus Yes No
- Student requires preferential seating on bus Yes No
- EpiPen can be found in: Backpack Waist pack On Person Other

Field Trip Procedures – EpiPen should accompany student during any school related off campus activities

- Certified staff member on trip must be trained regarding EpiPen use
- Health care plan will be reviewed prior to field trip
- Other _____

Student Considerations:

- Student is able to recognize signs and symptoms of exposure to allergen Yes No
- Student knows how to access emergency help in the school setting Yes No
- Other _____

School Environment Considerations:

- _____
- _____

****Student MUST be accompanied to health office if they are suspected of having an allergic reaction****

Parent/Guardian Authorization:

- I request this medication be administered as ordered by the student’s licensed health care provider.
- I give Health Services staff permission to communicate with the health care provider about this medication.
- I understand that these medications may be administered by certified staff members who have been trained in the administration of emergency medication.
- I agree that this medical information may be shared with school staff working with my child and 911 staff if needed.
- I assume responsibility for supplying medication to the school that will not expire during the course of its intended use.
Expired medication cannot be administered!
- Medication must be in the original prescription container with instructions as noted by above health care provider.
- I will provide an additional EpiPen in the health office if my child is authorized to self-carry.
- In the event of an emergency, I give my permission for transport and treatment at the nearest medical facility.

Health Care Provider’s Signature	Date:
Parent/Guardian Signature	Date:
Certified School Nurse Signature	Date:

****COMPLETE BOTH SIDES** (09/29/10)**