RCSD ROSEVILLE CITY SCHOOL DISTRICT
Est. 1869

ANAPHYLAXIS ACTION PLAN
(To be completed by physician)

Name:		**Birthdate:**		**Weight:**	**lbs.**	PHOTO HERE
Allergen(s):		**History of Asthma:**	☐ No ☐ Yes (*more risk for severe reaction)			
Student may:	☐ **self-carry Epinephrine Auto-Injector** ☐ **self-administer Epinephrine Auto-Injector**					
Student is extremely reactive to the following allergens:						

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

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: ☐ EpiPen ☐ Adrenaclick ☐ Auvi-Q

Epinephrine Dose (IM): ☐ 0.1 mg ☐ 0.15 mg ☐ 0.3 mg

Antihistamine: ☐ Benadryl ☐ Other:_____

Antihistamine Dose:_____

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

_____

My signature below provides the authorization for the above written orders. I understand that assistance with medications will be implemented in accordance with California state laws and regulations. I understand that specialized physical health care services and medication assistance may be performed by unlicensed, designated school personnel after training by the school nurse. If changes are indicated, I will provide new written authorization (may be faxed). Medication is authorized for one year from date below unless otherwise indicated.

MD/DO/PA Name (printed):			**Stamp:** (or address and phone)	
MD/DO/PA Signature:		**Date:**		

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ANAPHYLAXIS ACTION PLAN STUDENT DEMOGRAPHIC & HEALTH HISTORY (To be completed by parent)

(Please see reverse side for emergency anaphylaxis action plan to be completed by physician)

Student's Name:		Birthdate:		School:	
Other medical info:	☐ Asthma ☐ Inhaler ☐ Medical ID	Grade:		Teacher:	
Parent/Guardian Name:		Parent/Guardian Phone #			
Emergency Cont. Name:		Emergency Cont. Phone #			
Physician Name:		Physician Phone #			

HISTORY OF ALLERGIC REACTIONS:

Allergen(s):		**Total Reactions:**	
Treatment provided:		**Date of last Reaction:**	
How soon after exposure to allergen(s) did your child react?			
Early warning signs that indicate your child is starting to have a reaction:		**Does your child recognize these warning signs?**	☐ Yes ☐ No

What symptoms did your child experience during the allergic reaction(s) (please check all applicable boxes below):

☐ All over tingling or itching	☐ Coughing or sneezing	☐ Wheezing or difficulty breathing
☐ All over rash or hives	☐ Tightness of throat and/or chest	☐ Swelling of eyes, lips, tongue, throat or neck
☐ Dizziness or fainting	☐ Red face	☐ Vomiting, stomach cramping, or diarrhea
☐ Sudden mood change	☐ Seizures	☐ Blue or gray discoloration of lips or fingernails
☐ Loss of consciousness	☐ Other:	

Does your child know how to avoid known allergens?	☐ No ☐ Yes--*(Please check what your child does to avoid reaction below)*:
☐ Tells others about their allergies	☐ Tells an adult **immediately** if exposed to an allergen
☐ Firmly refuses food that might be a problem	☐ Asks about ingredients in foods, if unsure about the contents
Does your child need to sit at a peanut/nut-free table at school?	☐ Yes ☐ No

SIGNATURES

Parent/Guardian Signature:		Date:	

Parent/Guardian (Authorization and Disclaimer): My signature above provides authorization for this Anaphylaxis Action Plan (AAP). I request that the school assist my child with the medications included in the AAP in accordance with state laws and regulations. Should the doctor determine that my child is competent to self-carry and self-administer the medications listed on the AAP, I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of the medications listed on the AAP. I understand that medication assistance may be performed by unlicensed, designated school personnel after the training by the school nurse. I authorize staff to communicate with the physician regarding my child's medical condition and/or the medications prescribed for it. I have read and agree with the information provided above. I understand and give my consent for this information to be shared with school, transportation, and emergency personnel as deemed necessary to provide quality of care. This consent is valid for one year from date unless otherwise stated and may be revoked at any time.

District Nurse Signature:		Principal Signature:	