












**ANAPHYLAXIS ACTION PLAN**  
(To be completed by physician)

<b>Name:</b>		<b>Birthdate:</b>		<b>Weight:</b>	<b>lbs.</b>	<b>PHOTO HERE</b>
<b>Allergen(s):</b>		<b>History of Asthma:</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes (*more risk for severe reaction)			
<b>Student may:</b>	<input type="checkbox"/> self-carry Epinephrine Auto-Injector <input type="checkbox"/> self-administer Epinephrine Auto-Injector					
<b>Student is extremely reactive to the following allergens:</b>						

- ☐ 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: <b>SEVERE SYMPTOMS</b>	<b>MILD SYMPTOMS</b>
<div>   <b>LUNG</b>            Short of breath, wheezing, repetitive cough         </div> <div>   <b>HEART</b>            Pale, blue, faint, weak pulse, dizzy         </div> <div>   <b>THROAT</b>            Tight, hoarse, trouble breathing/ swallowing         </div> <div>   <b>MOUTH</b>            Significant swelling of the tongue and/or lips         </div>	<div>   <b>NOSE</b>            Itchy/runny nose, sneezing         </div> <div>   <b>MOUTH</b>            Itchy mouth         </div> <div>   <b>SKIN</b>            A few hives, mild itch         </div> <div>   <b>GUT</b>            Mild nausea/ discomfort         </div>
<div>   <b>SKIN</b>            Many hives over body, widespread redness         </div> <div>   <b>GUT</b>            Repetitive vomiting, severe diarrhea         </div> <div>   <b>OTHER</b>            Feeling something bad is about to happen, anxiety, confusion         </div> <div> <b>OR A COMBINATION</b>            of symptoms from different body areas.         </div>	<p><b>FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE</b></p> <p><b>FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:</b></p> <ol style="list-style-type: none"> <li>Antihistamines may be given, if ordered by a healthcare provider.</li> <li>Stay with the person; alert emergency contacts.</li> <li>Watch closely for changes. If symptoms worsen, give epinephrine.</li> </ol>
<ol style="list-style-type: none"> <li><b>INJECT EPINEPHRINE IMMEDIATELY.</b></li> <li><b>Call 911.</b> Tell them the child is having anaphylaxis and may need epinephrine when they arrive.           <ul style="list-style-type: none"> <li>Consider giving additional medications following epinephrine:               <ul style="list-style-type: none"> <li>Antihistamine</li> <li>Inhaler (bronchodilator) if wheezing</li> </ul> </li> <li>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.</li> <li>If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.</li> <li>Alert emergency contacts.</li> <li>Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.</li> </ul> </li> </ol>	<p align="center"><b>MEDICATIONS/DOSES</b></p> <p>Epinephrine Brand: <input type="checkbox"/> EpiPen    <input type="checkbox"/> Adrenaclick    <input type="checkbox"/> Auvi-Q  <input type="checkbox"/> Neffy</p> <p>Epinephrine Dose (IM): <input type="checkbox"/> 0.1 mg    <input type="checkbox"/> 0.15 mg    <input type="checkbox"/> 0.3 mg</p> <p>Epinephrine Dose (Nasal Spray): <input type="checkbox"/> 1mg    <input type="checkbox"/> 2mg</p> <p>Antihistamine: <input type="checkbox"/> Benadryl    <input type="checkbox"/> Other: _____</p> <p>Antihistamine Dose: _____</p> <p>Other (e.g. inhaler-bronchodilator if wheezing): _____</p>

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.

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

## 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:	<input type="checkbox"/> Asthma <input type="checkbox"/> Inhaler <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What symptoms did your child experience during the allergic reaction(s) (please check all applicable boxes below):			
<input type="checkbox"/> All over tingling or itching	<input type="checkbox"/> Coughing or sneezing	<input type="checkbox"/> Wheezing or difficulty breathing	
<input type="checkbox"/> All over rash or hives	<input type="checkbox"/> Tightness of throat and/or chest	<input type="checkbox"/> Swelling of eyes, lips, tongue, throat or neck	
<input type="checkbox"/> Dizziness or fainting	<input type="checkbox"/> Red face	<input type="checkbox"/> Vomiting, stomach cramping, or diarrhea	
<input type="checkbox"/> Sudden mood change	<input type="checkbox"/> Seizures	<input type="checkbox"/> Blue or gray discoloration of lips or fingernails	
<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Other:		
Does your child know how to avoid known allergens?	<input type="checkbox"/> No <input type="checkbox"/> Yes--(Please check what your child does to avoid reaction below):		
<input type="checkbox"/> Tells others about their allergies	<input type="checkbox"/> Tells an adult <b>immediately</b> if exposed to an allergen		
<input type="checkbox"/> Firmly refuses food that might be a problem	<input type="checkbox"/> Asks about ingredients in foods, if unsure about the contents		
Does your child need to sit at a peanut/nut-free table at school?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

### SIGNATURES

Parent/Guardian Signature:		Date:	
<p>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.</p>			
District Nurse Signature:		Principal Signature:	