

Food Allergy and Anaphylaxis Emergency Care Plan

Student Name: _____ Grade: _____ DOB: _____

Allergy to: Food: _____ Bee Sting Other: _____

IF applicable, check only **ONE** box below:

- Give epinephrine immediately if the allergen was **LIKELY** encountered, for ANY symptoms
 Give epinephrine immediately if the allergen was **DEFINITELY** encountered, even if no symptoms

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.

Do This:

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. **Call 911** - Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive
 - Notify parent or emergency contact
 - Lay 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, another dose of epinephrine can be given 5 minutes or more after the last dose
 - Alert emergency contacts

Note: School personnel should not drive student to hospital

MILD SYMPTOMS:

For **MILD SYMPTOMS** from more than one system area, give epinephrine



NOSE

Itchy/runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea/ discomfort

For **MILD SYMPTOMS** from a **SINGLE SYSTEM** area, follow the directions below:

1. Antihistamines may be given, if ordered by a health care provider
2. Stay with person; alert emergency contacts
3. Watch closely for changes. If symptoms worsen, give epinephrine

MEDICATIONS/DOSES

Epinephrine Name: _____ **Epinephrine Dose:** 0.15 mg IM 0.3 mg IM

Antihistamine Name: _____ **Antihistamine Dose:** _____

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

Yes No Student has asthma Yes No Student has had a prior anaphylactic reaction

Yes No Student understands the proper use of his/her medication(s), and in my opinion, can carry and may self-administer epinephrine independently at school

HEALTH CARE PROVIDER INFORMATION

Signature: _____ **Date:** _____

Name (Print): _____ **Address:** _____

Phone: _____ **Fax:** _____

I, the undersigned, as parent/guardian request that the medication(s) be made available to my child at the times prescribed. I authorize the District Nurse, other designated school personnel or site administrator to contact my child's physician and pharmacist regarding this recommendation. I will provide the medication(s) in the prescription container(s) which is labeled with the name of the child, the prescribing physician's name, amount of medication prescribed, time to be administered and monitoring devices (if needed). I will notify the District Nurse, other designated School Personnel or site administrator, if there is a change to the student's medication, health status or authorized health care provider.

Parent Signature: _____ Date: _____ District Nurse Signature: _____ Date: _____