Literacy First Charter Schools
"The tree of knowledge begins with literacy."

School Anaphylaxis Action Plan

Student's Name:_____ Date of Birth:_____ Weight:_____ lbs

ALLERGY TO:_____

STEP 1: TREATMENT

Symptoms:		**Give checked medication as prescribed by physician authorizing treatment**		
	If a food allergen has been ingested, (or bee sting) but **no symptoms yet**: Treat:			Epinephrine
●	Mouth	Itching, tingling,or swelling of lips, tongue, mouth		Epinephrine
●	Skin	Hives, itchy rash, swelling of the face or extremities		Epinephrine
●	Gut	Nausea, Abdominal cramps, vomiting, diarrhea		Epinephrine
●	Throat †	Tightening of throat, hoarseness, hacking cough		Epinephrine
●	Lung †	Shortness of breath, repetitive coughing, wheezing		Epinephrine
●	Heart †	Weak or thready pulse, low blood pressure, fainting, pale, blueness		Epinephrine
●	Other:			Epinephrine

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

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace ephinephrine in anaphlaxis

PRESCRIBED DOSAGE

Ephinephrine: Inject intramuscularly **(Check ONE)**: ☼ **Junior Dose (0.15 mg)** or ☼ **Regular Dose (0.30 mg)**

SECOND DOSE After 10 minutes, if emergency services have not arrived and symptoms persist, administer 2nd dose.

Antihistamine or Asthma Inhalers: Note to prescribing doctor: When a nurse is not always present to distinguish symptoms of anaphylaxis from other allergic reactions, pediatric allergists recommend that action plans be as simple as possible. When a nurse will not always be present, it is advised that antihistamines not be a part of the action plan. Rather, auto-injectors and calling 911 for support should occur immediately.

Other Medication: Give:_____

medication/doses/route/indications

Medical Provider's Signature_____Licence #_____Date_____

School Nurse Signature_____Date_____

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Dr._____ Phone Number:_____
3. Parent:_____ Phone Number(s):_____
4. Other emergency contacts:

Name/Relation	Phone Number(s):
a._____	_____
b._____	_____
c._____	_____

I will notify the school immediately and submit a new form, if there are changes in the medication or dosage, time of administration, or a change in the prescribing physician. I give school permission to contact the physician when necessary.

Parent/Guardian's Signature_____Date_____