WFISD

Department of School Health Services

Place Student's Picture Here

ANAPHYLAXIS (ALLERGY) EMERGENCY ACTION PLAN

Name: _____ **AGE:** _____ **DOB:** _____

Allergy to: _____

Asthma: ☐ Yes (higher risk for severe reaction) ☐ No

Other health problems besides anaphylaxis: _____

Concurrent medications, if any: _____

_____

SYMPTOMS OF ANAPHYLAXIS INCLUDE:

MOUTH	**itching, swelling of lips and/or tongue**
THROAT*	**itching, tightness/closure, hoarseness**
SKIN	**itching, hives, redness, swelling**
GUT	**vomiting, diarrhea, cramps**
LUNG*	**shortness of breath, cough, wheeze**
HEART*	**weak pulse, dizziness, passing out**

Only a few symptoms may be present. Severity of symptoms can change quickly.

Some symptoms can be life-threatening! ACT FAST!

WHAT TO DO:

1. **IF STUDENT IS ALERT WITH NO BREATHING PROBLEMS, immediately send student to the nurse, accompanied by another student or staff member.**

   IF STUDENT IS HAVING ANY DIFFICULTY BREATHING, OR IS NOT ALERT, call nurse to classroom immediately with epi pen.

2. **INJECT EPINEPHRINE IN THIGH USING (check one):** ☐ EpiPen Jr. (0.15 mg) ☐ Twinject 0.15 mg ☐ EpiPen (0.3 mg) ☐ Twinject 0.3 mg

   Other medication/dose/route:_____

IMPORTANT! ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS!

3. **CALL 911 (BEFORE CALLING CONTACT)!**

DO NOT HESITATE TO GIVE EPINEPHRINE! See back for auto-injection technique.

_____

Physician's Signature/Date

4. EMERGENCY CONTACTS

#1:Name:_____ home: _____ work: _____ cell: _____

#2 Name:_____ home: _____ work: _____ cell: _____

#3 Name:_____ home: _____ work: _____ cell: _____

5. TRAINED STAFF MEMBERS

#1: Name: _____ Room: _____

#2: Name: _____ Room: _____

#3: Name: _____ Room: _____

_____ _____

Parent's Signature/Date **RN's Signature/Date**