Severe Allergy Indicator
Anaphylaxis Care Plan

Student's Name:______________________ DOB:__________ Teacher:____________________

ALLERGY TO:____

Asthmatic ☐Yes* ☐ No *Higher risk for severe reaction

◆ STEP 1: LEVEL OF SEVERITY: ◆

To be completed by Health Care Provider:

☐ Treatment to be with Student at all times
☐ Treatment should be initiated immediately following exposure without waiting for symptoms
☐ Treatment should be initiated only following the appearance of symptoms

Can this child self carry? ☐ Yes ☐ No

◆ STEP 2: TREATMENT ◆

Symptoms: An allergic reaction may include any or all of these symptoms		**Give Checked Medication****	
		**(to be determined by physician authorizing treatment)	
• If a food allergen has been ingested, but *no symptoms*:		☐ Epinephrine	☐ Antihistamine
• Mouth	Itching, tingling or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
• Throat †	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
• Lung †	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
• Heart †	Weak or thread pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
• General †	Dizziness, loss of consciousness feeling of panic	☐ Epinephrine	☐ Antihistamine
• If reaction is progressing (several of the above areas affected), give:		☐ Epinephrine	☐ Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly (circle one): EpiPen ® EpiPen Jr. ® Twinject ® 0.3 mg Twinject ® 0.15

Antihistamine: give____
Medication/dose/route/duration

Other: give____
Medication/dose/route/duration

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis

◆ STEP 3: EMERGENCY CALLS ◆

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed
2. Dr.______________________________ at______________________________
3. Emergency Contacts:

Name/Relationship	Phone Number(s)	
a. ____________________	1.)____________________	2.)____________
b. ____________________	1.)____________________	2.)____________
c. ____________________	1.)____________________	2.)____________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY

Signature authorizes the parties listed to share confidential information with appropriate school personnel on a "need-to-know" basis

Parent/Guardian Signature______________________________ Date______________

Doctor's Name:______________________________ Phone Number:______________
(Please Print)

Doctor's Signature______________________________ Date______________
(Required)

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