Severe Allergy Indicator
Anaphylaxis Care Plan

Student's Name:_____ DOB:_____ Teacher:_____

ALLERGY TO:_____

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

Place Child's Picture Here

◆ 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

- If a food allergen has been ingested, but *no symptoms*:
- Mouth Itching, tingling or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat † Tightening of throat, hoarseness, hacking cough
- Lung † Shortness of breath, repetitive coughing, wheezing
- Heart † Weak or thread pulse, low blood pressure, fainting, pale, blueness
- General † Dizziness, loss of consciousness feeling of panic
- If reaction is progressing (several of the above areas affected), give:

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

Give Checked Medication**

**(to be determined by physician authorizing treatment)

☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine

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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