



ALLERGY & ANAPHYLAXIS HEALTH PLAN



Insert

Student

Photo

Student Name: _____ Grade: _____ DOB: _____

School Site/Teacher: _____

Allergen(s): _____

Reaction: _____

Student self-carry order on file for Epinephrin ("Epi-Pen"): ☐ No ☐ Yes

Possible ANAPHYLAXIC Reaction to: _____ THEREFORE, if checked:

☐ Give Epi-Pen immediately if **LIKELY** exposure to allergen (eaten), for **ANY** symptoms.

☐ Give Epi-Pen immediately if **DEFINITELY** exposure to allergen (eaten), even if no symptoms are apparent.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

FOR ANY OF THE FOLLOWING: SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue 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.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the 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, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE
SYSTEM AREA, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM
AREA, FOLLOW THE DIRECTIONS BELOW:**

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

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

ALLERGY & ANAPHYLAXIS Health Plan for: _____ Grade: ____ DOB: _____

EMERGENCY CONTACTS:

Mother/Father/Other: _____ Contact #: _____

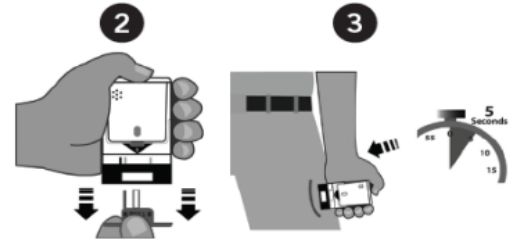
Mother/Father/Other: _____ Contact #: _____

For Students with orders allowing self-carry of Epi-pen: Validate student's understanding of appropriate Epi-Pen use and storage while at school and on bus (if applicable).

Staff member name: _____ Date of validation: _____ ☐ N/A

AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



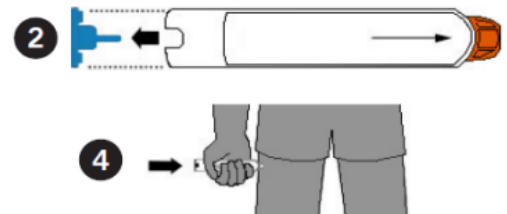
ADRENALCLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.



EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



FOR SEVERE FOOD ALLERGIES: Parent/guardian will: 1) Provide completed Student Medication Permission form for any medications at school, 2) Complete the Meal Accommodation form if school provided meals are requested 3) Coordinate with Teacher/Staff to ensure "safe" treats are available in the classroom or during school sponsored events.

☐ IF checked, student will be required to sit at a "nut free" table.

☐ IF checked, informative letter will be sent to classmates requesting a nut free classroom.

Parent/Guardian (name/signature): _____ Date: _____

Reviewed by Health Office (name/signature): _____ Date: _____

Reviewed by District RN (name/signature): _____ Date: _____

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017 and FARE Food Allergy & Anaphylaxis Emergency Care Plan 2020.