

Place Child's  
Picture Here



## Prevention Plan

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Teacher's Name: \_\_\_\_\_ Room #: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Asthmatic? Y/N) \_\_\_\_\_ (Yes=Higher Risk for Severe Reaction)

### School will:

- A Certified Medication Technician on site with on-call Delegating RN
- Have staff trained in CPR & First Aid
- Have staff trained in Allergy & Anaphylaxis  
→ administering EpiPen® including demonstration & practice
- Emergency List distributed to: \_\_\_\_\_
- Have staff trained on individual emergency plans
- School staff will make every reasonable effort to prevent the student's exposure to known allergens
- Other \_\_\_\_\_

### Parents will:

- Provide pertinent health information to the school
- Provide Physician Authorization Forms and Action Plans  
→ for student medication and specific actions plans for emergency care
- Current, non-expired medications
- Provide safe snack option to school/classroom
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

### Student will:

- Make every effort to avoid contact with allergen
- Alert nearest adult if suspect exposure to allergen
- Other

### Notes:


Place Child's  
Picture Here

# Management of Severe Allergic Reactions & Anaphylaxis



**Student's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Teacher's Name:** \_\_\_\_\_ **Room #:** \_\_\_\_\_  
**ALLERGY TO:** \_\_\_\_\_  
**Asthmatic? (Y/N)** \_\_\_\_\_ (Yes=Higher Risk for Severe Reaction)

## STEP 1: TREATMENT

Symptoms	Give This Medication	
	Epinephrine	Antihistamine
If a food allergen is ingested or suspected bee sting, but <i>no symptoms</i>		
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		
Other:		
If reaction is progression (several of the above areas affected):		

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

### DOSAGE

**Epinephrine:** inject intramuscularly:

EpiPen® \_\_\_\_\_ EpiPen JR® \_\_\_\_\_ Auvi-Q \_\_\_\_\_  
or generic \_\_\_\_\_ or generic \_\_\_\_\_

**Antihistamine:** give \_\_\_\_\_

**Other:** give \_\_\_\_\_

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

## STEP 2: EMERGENCY CALLS

Call 911 (or Rescue Squad). State that an allergic reaction has been treated and additional epinephrine made be needed.

\_\_\_\_\_  
**Doctor's Name** \_\_\_\_\_ **Doctor's Phone Number** \_\_\_\_\_  
\_\_\_\_\_  
**Parent's Name** \_\_\_\_\_ **Parent's Phone Number** \_\_\_\_\_  
\_\_\_\_\_  
**Emergency Contact 1 Name/Relationship** \_\_\_\_\_ **Emergency Contact 1 Phone Number** \_\_\_\_\_

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

\_\_\_\_\_  
**Parent Guardian's Signature/Date** \_\_\_\_\_ **Doctor's Signature/Date** \_\_\_\_\_