School District of South Orange-Maplewood
Anaphylaxis Emergency Health Care Plan

Student's Name: _____ **DOB:** _____

School: _____ **Teacher:** _____ **Grade:** _____

ALLERGY TO: _____

Asthmatic **Yes*** ☐ **No** ☐ **(***Higher Risk for Severe Reaction)

Location of Auto Injector: _____

DESIGNEES MAY ONLY ADMINISTER EPINEPHRINE VIA AN AUTO INJECTOR

STEP 1: TREATMENT

Symptoms:	**Administer Checked Medication**** ** To be determined by physician authorizing treatment
■ If a food allergen has been ingested, but *no symptoms:*	☐ Epinephrine ☐ Antihistamine ☐Steroid
■ Mouth - Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine ☐Steroid
■ Skin - Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine ☐Steroid
■ Gut - Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine ☐Steroid
■ *Throat -Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine ☐Steroid
■ *Lung - Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine ☐Steroid
■ *Heart - Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine ☐Steroid
■ Other _____	☐ Epinephrine ☐ Antihistamine ☐Steroid
■ **If reaction is progressing (several of the above areas affected), administer:**	☐ Epinephrine ☐ Antihistamine ☐Steroid

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

MEDICATION DOSAGE

Epinephrine autoinjector 0.3mg (66 lbs & up) **Epinephrine,Jr autoinjector 0.15mg (33-66lbs)**

Inject intramuscularly to outer thigh

Antihistamine: give _____

Steroid: give _____

STEP 2: EMERGENCY CALLS

1. **CALL 911!! State that an allergic reaction has been treated, and additional epinephrine may be needed.**
2. Call Dr._____ Phone Number _____
3. Call Parent/Guardian_____ Phone Number(s) _____
   Phone Number _____
4. Emergency Contacts: Name/Relationship
   a. _____ Phone Number _____
   b. _____ Phone Number _____

Parent/Guardian's Signature _____ **Date** _____

Physician's Signature _____ **Date** _____
(Required)

4//2017