



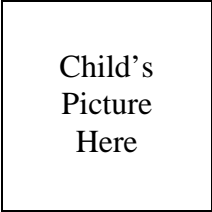
ALLERGY AND ANAPHYLAXIS EMERGENCY CARE PLAN

HEALTH SERVICES
SCHOOL DISTRICT U-46

Student Name _____ School Year _____

Date of Birth _____ Teacher/Grade _____

Child is allergic to _____



Child Has Asthma Yes No

Child Has Had Anaphylaxis Yes No

Child May Self- Carry Medicine Yes No

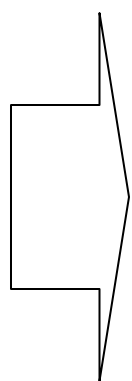
Child May Self Administer Yes No

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION/STING:

- LUNG: shortness of breath, wheeze, coughing
- HEART: pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Obstructive swelling (tongue)
- SKIN: Many hives all over body

Or Combination of symptoms from different body areas:

- SKIN: Hives, itchy rashes, swelling
- GUT: Vomiting, crampy pain



INJECT EPINEPHRINE IMMEDIATELY

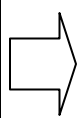
- ~Call 911
- ~Begin Monitoring (see below)
- ~Additional Medications:
 - ~Antihistamine
 - ~Inhaler (bronchodilator) if Asthma

*Inhalers/bronchodilators and antihistamines are not to be depended on to treat a severe reaction (anaphylaxis)→Use Epinephrine.

**When in doubt, use Epinephrine. Symptoms can rapidly become more severe.

MILD SYMPTOMS ONLY

- Mouth: Itchy mouth
- Skin: A few hives around mouth/face, mild itch
- Gut: Mild nausea/discomfort



GIVE ANTIHISTAMINE

~ Stay with child, alert health care professionals and parent

IF SYMPTOMS PROGRESS (see above). INJECT EPINEPHRINE

SPECIAL SITUATION: If this box is checked, child has an EXTREMELY severe allergy to insect sting or the following food(s):_____. Even if the child has MILD symptoms after a sting or eating these foods, **give epinephrine**

MEDICATIONS/DOSES (Medication permission forms needed for each medication)

EPINEPHRINE (BRAND/DOSE): _____

ANTIHISTAMINE (BRAND/DOSE): _____

Other (e.g. Inhaler/Bronchodilator if asthma): _____

MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first dose if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

Physician Signature (REQUIRED) _____

_____ Date

_____ Phone Number

Parent/Guardian Signature _____

_____ Date

_____ Phone Number