Twin Valley School District

Anaphylaxis Medication Order & Emergency Action Plan

Student Name: _________________________________ Date of Birth: ____________________ Grade: _________

Life Threatening Allergen(s):____

Does student have Asthma: _____ Yes (high risk for severe reaction) ____ No

Additional health problems besides anaphylaxis: ____

Concurrent Medications: ____

Symptoms of Anaphylaxis:

MOUTH: *itching, swelling of lips and /or tongue*
THROAT*: *itching tightness/closure, hoarseness*
SKIN: *itching, hives, redness, swelling*
GUT: *vomiting, diarrhea, cramps*
LUNGS*: *Shortness of breath, cough, wheeze*
HEART*: *weak pulse, dizziness, passing out*

Only a few symptoms may be present. Severity of symptoms can change quickly!
Some symptoms can be lift-threatening.* ***ACT FAST!*

EMERGENCY ACTION STEPS- DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine into thigh using (check one):

☐ **Epinephrine Auto-injector (0.15mg)** ☐ **Epinephrine auto-injector (0.3 mg)**

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED UPON DURING ANAPHYLAXIS.

2. Call 911 or rescue squad first then call emergency contact listed below:
3. Contact ______________: home _________________ work ________________ Cell __________________
   Contact ______________: home _________________ work ________________ Cell __________________
   Contact ______________: home _________________ work ________________ Cell __________________

Physician Authorization

_____ I believe this child is able and responsible to carry and self-administer his/her epinephrine auto-injector during school activities. He/she has permission to so do and has been instructed on how to self-administer.

____ ____
Physician's Signature Physician's Name Printed

____ ____
Date Phone Number

Parent/Guardian Authorization

Additionally, **I agree to hand deliver** the medication to the nurse's office in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give my permission for the school and physician to communicate regarding this medication and medical condition.

_____ I believe my child is able and responsible to carry and self-administer his/her epinephrine auto-injector in school, during field trips, and extra-curricular activities (including athletics and music). I give my permission for him/her to do so. If my child uses his/her epinephrine auto-injector he/she will notify the nurse as soon as possible after using the medication.

________________ ____________________________ ____________________________
Date Printed Parent/Guardian Name Parent/Guardian Signature

(Student may carry epinephrine auto-injector upon clearance by the nurse)

(School Use Only ________Clearance to carry and self- administer epinephrine auto-injector has been given and initialed by the school nurse.) Adapted from the 2016 American Academy of Allergy, Asthma, & Immunology. Rev. 1/2017