Winfield Public Schools
USD 465
Anaphylaxis Emergency Action Plan

Student Name:_____ Age:_____

Allergies:_____ Asthma: Yes_____ 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**
Lung	**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 life-threatening. ACT FAST!

Emergency Action Steps-DO NOT HESITATE TO GIVE EPINEPHRINE!

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

MEDICATIONS/DOSES

Epinephrine Brand _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

May student self-carry epinephrine pen? ____YES ____NO
Specify Orders: _____

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

2. Call 911 or rescue squad (before calling contact)
3. Emergency Contact #1: Name_____ _____ Phone Number:_____
   Emergency Contact #2: Name_____ _____ Phone Number:_____
   Emergency Contact #3: Name_____ _____ Phone Number:_____
   Comments: _____ _____

SPECIAL CONSIDERATIONS, PRECAUTIO
(regarding school activities, sports, trips, etc.)
____Bus transportation_____ _____
____Field Trips: Who will carry/administer epinephr _____
____After school activities_____
____504 accommodations (See 504 Plan)_____

DISTRIBUTION DATE(S):

Principal_____ Teacher (Include copy in your substitute folder)_____ Parent/Guardian _____ Nutrition____Other____

Parent Signature:_____ **Date:**_____
School Nurse Signature:_____ **Date:**_____
Doctor Signature:_____ **Date:**_____