

ACTION PLAN FOR ANAPHYLAXIS

Patient's Name		Date of Birth	Expiration Date for Action Plan
Health Care Provider		Provider's Phone Number	
Responsible Person (i.e. parent/guardian)		Phone Number	
Emergency Contacts	Home Telephone Number	Work Number	Cellular Number
1.			
2.			
Patient's known severe allergies:			

WATCH FOR SIGNS AND SYMPTOMS OF ANAPHYLAXIS

Medication:

To prevent anaphylaxis shock administer a one time injection in thigh or specify other location

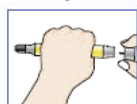
- EpiPen Jr. (0.15 mg)
- EpiPen (0.3 mg)
- Other _____

Only a few signs and symptoms may be present. Severity of symptoms can change quickly. Some symptoms can be life threatening:

- **Rash (especially hives) with redness and swelling especially on face, lips and tongue**
- **Shortness of breath, cough, wheeze**
- **Difficulty talking and/or hoarse voice**
- **Abdominal pain, vomiting, diarrhea**
- **Loss of consciousness**

ACT QUICKLY !!!!!

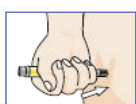
How to give EpiPen® or EpiPen® Jr (can be administered through clothing)



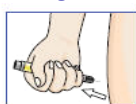
1. Form fist around EpiPen® and pull off grey cap.



2. Place black end against outer mid-thigh.



3. Push down **HARD** until a click is heard or felt and hold in place for 10 seconds.



4. Remove EpiPen® and be careful not to touch the needle. Massage the injection site for 10 seconds.

- 1. Stay with the child and have someone call 911.**
- 2. Locate EpiPen (epinephrine).**
- 3. Oversee or assist child in injecting the epinephrine in thigh using medication listed above.**
- 4. Contact responsible person or other emergency contacts listed above.**

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN AND YOUTH:

Healthcare Providers Initials

_____ This student was trained and is capable to self-administer with the auto injectable epinephrine pen

_____ This student is not approved to self-medicate

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Permission to Reproduce Blank Form

Health Care Provider's Signature

Date

As the Responsible Person, I hereby authorize a trained school employee to administer medication to the student

As the Responsible Person, I hereby authorize this student to possess and self-administer medication.

I hereby acknowledge that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under D.C. Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct



Responsible Person's Signature

Date