# Emergency Action Plan: Anaphylaxis

**Name:** ______________________________________________

**ALLERGIC TO:** ______________________________ Program ____________ School Year__________

**Warning Signs - If You See This:**

For **Any** of the Following **SYMPTOMS**
*(Stay with individual. Never leave alone.)*
**One or more of the following:**

**LUNG:** Short of breath, wheezing, repetitive coughing

**HEART:** Pale, blue, faint, weak pulse, dizzy, confused

**THROAT:** Tight, hoarse, trouble breathing and/or swallowing/speaking

**MOUTH:** Significant swelling of the tongue and/or lips

**SKIN:** Many hives over body, widespread redness

**GUT:** Repetitive vomiting, severe diarrhea

**NEURO:** Feeling something bad is about to happen, anxiety, fear

**Do This:**

**Notify Green Team Immediately**
If ordered (see below), student may self-administer epinephrine

**Green Team:**

Upon confirmation of symptoms:

**INJECT EPINEPHRINE AUTOINJECTOR IMMEDIATELY! (See medication/dosage below)**

Call EMS (911)

Begin monitoring (see box below)

Send used autoinjector(s) to emergency department with individual or discard appropriately

## MONITORING

**Monitoring after 911 is called** – Airway, Breathing, and Cardiac.
**Stay with individual; alert healthcare professional, principal and parent.**
Note:

- ☑ Record time epinephrine autoinjector used and inform rescue squad upon arrival.
- ☑ Continue to keep on back with legs elevated legs above the heart. If difficulty breathing or vomiting present, let individual sit up or lie on side.
- ☑ Provide First Aid/CPR as necessary; AED if necessary and available.

## MEDICATION/DOSAGE

- ☐ 0.15mg Epinephrine autoinjector IM, if less than 66 pounds
- ☐ 0.30mg Epinephrine autoinjector IM, if 66 pounds or more
- ☐ A second epinephrine autoinjector dose can be given 5 or more minutes after the first if symptoms persist or recur.

- ☐ Student may carry and administer his/her own epinephrine auto-injector
- ☐ Student may carry his/her own epinephrine auto-injector, but will need assistance with administration

- ☐ Additional orders: ____________________________________________

## AUTHORIZED SIGNATURES

**Licensed Healthcare Professional Authorized to Prescribe**

Name/Title (Printed): ______________________________ Phone: ______________

Signature: ______________________________ Date: ______________

Parent Name (Printed): ______________________________ Phone: ______________

Signature: ______________________________ Date: ______________

School Nurse Review: ______________________________ Date: ______________
Laura J. Robusto, MSN, RN, School Nurse

Adapted from ODH Anaphylaxis EAP
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