HARRISON COUNTY SCHOOL DISTRICT
ANAPHYLAXIS EMERGENCY ACTION PLAN

Plan valid for one school year

Date of Plan:	**Allergy To:**	**Asthmatic*:** ☐ **Yes** ☐ **No**
Student Name:	**Date of Birth:**	**Grade:**
School:	**Teacher:**	

EMERGENCY CONTACTS:

*Higher risk of severe reaction

Parent/Guardian Name(s):	**Phone Number(s):**
Name/Relationship:	**Phone Number:**
Name/Relationship:	**Phone Number:**
Physician's Name:	**Phone Number:**
Hospital:	**Phone Number:**

STEP 1: TREATMENT
If the following symptoms appear:

Give checked medication: *(to be determined by physician authorizing treatment)*

Symptoms		
☐ Exposure to allergen has occurred but no symptoms present	☐ Epinephrine	☐ Antihistamine
☐ Mouth – Itching, tingling, swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
☐ Skin – Hives, itchy rash, swelling of face or extremities	☐ Epinephrine	☐ Antihistamine
☐ Gut – Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
☐ Throat – Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
☐ Lung – Shortness of breath, repetitive cough, wheezing	☐ Epinephrine	☐ Antihistamine
☐ Heart – Thready pulse, low blood pressure, fainting, pale or blueness	☐ Epinephrine	☐ Antihistamine
☐ Other: ____________________	☐ Epinephrine	☐ Antihistamine
☐ If reaction is progressing (several of the above areas affected), give	☐ Epinephrine	☐ Antihistamine

DOSAGE:

Epinephrine: intramuscular injection (choose one) ☐ EpiPen ☐ EpinPen Jr. ☐ Twinject 0.3 mg ☐ Twinject 0.15 mg

This student is allowed to: ☐ Carry epinephrine ☐ Self-administer ☐ Administer with supervision at school

Antihistamine: ____________________

Other: ____________________

☐ This student should be allowed to carry and use this medication by him/herself.

☐ This student should be allowed to carry this medication but will need supervision by a school nurse or trained personnel to use this medication.

☐ This student should <u>not</u> be allowed to carry and use this medication by him/herself at school. Assistance should be provided by the school nurse or trained staff in taking the medication.

☐ This medication must accompany this student on all field trips or off-campus activities.

____________________ ____________________

Healthcare Provider's Signature Date

STEP 2: Emergency Calls

1. Call 911. State that an allergic reaction has been treated and epinephrine may be needed.
2. Notify the school nurse and parent (emergency contacts listed above).
3. Call Dr. ____________________ at ____________________.

For completion by parent or legal guardian

As the parent/guardian of the above-named student, (check one or both statements below)

☐ I ask that my child be permitted to carry the medication listed above and self-medicate as authorized by myself and my physician. I release Harrison County School District from liability for any injury arising from self-administration by my child.

☐ I ask that assistance by the school nurse or trained staff be provided to my child in taking the indicated medication. Authorization is hereby granted to release this information to appropriate school personnel. I give my permission for the prescribing health care provider named above to release medical information pertaining to this medication to Harrison County School District.

____________________ ____________________

Parent Signature Date

____________________ ____________________

School Nurse Signature Date

DOCUMENTATION OF INSTRUCTION AND TRAINING

STUDENT	SCHOOL

The following school personnel have been given instruction on the proper technique of administering the following:

☐ EpiPen® ☐ EpiPen® Jr. ☐ Twinject 0.3mg ☐ Twinject 0.15mg

Understanding was shown through the following:

☐ Verbal Return ☐ Return Demonstration

School Personnel	Job Title	Date
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School Personnel	Job Title	Date
School Personnel	Job Title	Date
School Personnel	Job Title	Date
School Personnel	Job Title	Date
School Personnel	Job Title	Date
Instructor	Job Title	Date