Pulaski County Schools
Food Allergy & Anaphylaxis Emergency Care Plan

Place Child's Picture Here

Student's Name: _____D.O.B:_____

Allergy to: _____

Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No Weight: _____

Treatment Plan: If checked give medication

Systems/Symptoms		
• **Mouth:** Significant swelling of tongue and/or lips	☐ **Epinephrine**	☐ **Antihistamine**
• **Skin:** Many hives over body, itchy rashes, swelling eyes/lips	☐ **Epinephrine**	☐ **Antihistamine**
• **Gut:** Nausea, abdominal cramps, vomiting, diarrhea	☐ **Epinephrine**	☐ **Antihistamine**
• **Throat:** Tight, hoarse, hacking cough, trouble breathing/swallowing	☐ **Epinephrine**	☐ **Antihistamine**
• **Lung:** Short of breath, repetitive coughing, wheezing	☐ **Epinephrine**	☐ **Antihistamine**
• **Heart:** Pale, blue, faint, weak pulse, dizzy	☐ **Epinephrine**	☐ **Antihistamine**
• **Other:** Feeling something bad is about to happen, anxiety, confusion	☐ **Epinephrine**	☐ **Antihistamine**

For any of the above **SEVERE SYMPTOMS** inject epinephrine immediately**. Call 911,** tell them the child is having anaphylaxis and may need more epinephrine when they arrive. For **Mild Symptoms** from more than one system area, give Epinephrine. For mild symptoms from a single system area antihistamines may be given. Stay with person and watch closely for changes. If symptoms worsen, give epinephrine.

Medications/Doses

Epinephrine Brand: _____ Dose: ☐0.15 mg IM ☐ 0.3 mg IM
Antihistamine Brand: _____ Dose: _____
Other (e.g. inhaler-bronchodilator if asthmatic): _____

EMERGENCY PLAN OF ACTION

Call 911 immediately. Stay with the student; alert healthcare professionals and parent. Note the time when epinephrine was administered. A second dose can be given 5 minutes or more after the first if symptoms do not improve, or symptoms return. Transport student to ER even if symptoms resolve.

Dr. _____Phone Number: _____
Parent _____Phone Number: _____
Emergency contact: _____Phone Number: _____

_____This student has been instructed in the proper way to use his/her epinephrine. It is my professional opinion that this student is responsible and should be allowed to carry and self-administer his/her epinephrine.
____This student has an order for antihistamine and has been instructed on when to use for symptoms of allergic reaction. Student may carry only one dose for self administration**.**
____ It is my professional opinion that this student **should not** carry his/her epinephrine or antihistamine at school. The epinephrine/antihistamine will be kept in the health clinic and administered by the school nurse and/or designated trained staff.
This plan of care is in accordance with the student's medical management and is to be followed at school.

Physician Signature: _____ Date: _____
Parent/Guardian's Signature: _____Date: _____

Revised: May 12, 2016

Student Name: _____DOB: _____

Outline a plan for classroom parties and/or food in classroom: _____
_____
Outline a plan for field trips: _____
_____

Parent /Guardian Consent: I have received and approve this health care and emergency action plan for my child. I authorize unlicensed trained personnel of Pulaski County Schools to administer and/or assist my child with an **epinephrine** and/or other prescribed medication as outlined in this plan in the absence of the school nurse. I understand that I am responsible for supplying any medication, supplies and/or equipment, and dietary supplements needed by my child to manage his/her allergy/reaction. This health care plan can be updated at any time my child's circumstances require modifications in treatment, but will be reviewed annually. I agree to notify the school if a change occurs in my child's health plan. I also consent to the release of the information contained in this care plan to Pulaski County Public School personnel who care for my child and who may need to know this information to maintain my child's health and safety.

Parent/Guardian Signature _____Date _____

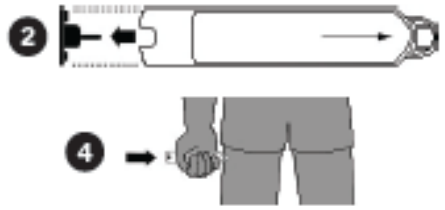
School Nurse Signature _____Date _____

TRAINED STAFF MEMBERS

1.	Location:
2.	Location:
3.	Location:

EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

May 12, 2016