Teacher/Grade: _____ Location of Epinephrine: _____

Lawrence Township Public Schools

Allergic Reaction Action Plan

Place Student's Picture Here

Name: _____ DOB: ___/___/___

Allergy to: _____

Weight: _____lbs. **Asthma:** ☐ **YES** *(higher risk for severe reaction)* ☐ NO

Extremely reactive to the following foods/allergen: _____
THEREFORE:

☐ **If checked**, give epinephrine immediately for **ANY** symptoms if the allergen is ***likely*** eaten.

☐ **If checked**, give epinephrine immediately if the allergen was ***definitely*** eaten, even if no symptoms are noted.

Any **SEVERE SYMPTOMS** after suspected or known ingestion:

ONE OR MORE of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **COMBINATION** of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. **Call 911**
3. Begin monitoring (see box below)
4. Give additional medications:*
   - ♦Antihistamine
   - ♦Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis).

USE EPINEPHRINE

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

1. GIVE ANTIHISTAMINE
2. Stay with student and contact parent
3. If symptoms progress (see above)
   USE EPINEPHRINE
4. Begin monitoring (see box below)

MONITORING

Stay with student; call 911 & parent. Tell rescue squad epinephrine was given; **request an ambulance with epinephrine**. **Note time when epinephrine was administered**. **A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur**. For severe reaction, consider keeping student lying on back with legs raised. **Treat student even if parents cannot be reached**.

MEDICATIONS/DOSES:

Epinephrine: **inject IM outer thigh** *(circle one)* → **EpiPen®Jr. 0.15mg** | **EpiPen® 0.3mg** | **Twinject® 0.15mg** | **Twinject® 0.3mg**

Antihistamine: _____

Medication / Dose /Route

SELF-ADMINISTRATION OF MEDICATION

☐ This student is **NOT** capable of self-administering the medications named above.

☐ This student has been trained & is capable of self-administering the medications named above.

Medications orders EFFECTIVE DATE: ___/___/___ →→→→ **CONCLUSION DATE:** ___/___/___

PHYSICIAN'S SIGNATURE: _____ **PARENT SIGNATURE:** _____

Date: _____ **Phone:** _____ **Date:** _____

STAMP: **Reviewed by Chief Medical Inspector:**