2023-24 SY Bartow County School System Anaphylaxis Plan

Student _____ **Age** _____ **Date of Birth** _____

Diagnosis(es) _____

Allergy: Insect sting _____ Food _____ Latex _____ Medication _____

Food Allergy: _____

Other: _____

History of anaphylaxis YES _____ NO _____
History of asthma (high risk for severe reaction) YES _____ NO _____

Other health history: _____

Current medications: _____

Signs & Symptoms of Anaphylaxis
Emotions may appear anxious or express a sense of doom **Mouth** itching, swelling of lips and/or tongue ***Throat** itching, hoarseness, tightness, closure **Skin** itching, redness, swelling, hives **Gut** cramps, vomiting, diarrhea ***Lung** cough, wheezing, shortness of breath ***Heart** dizziness, weak pulse, passing out *These symptoms can be life threatening – ***ACT FAST***
Only a few signs and symptoms may be present, and severity can change quickly. **ADMINISTER EPINEPHRINE IMMEDIATELY** if two or more symptoms are present *or* one symptom after a known allergen exposure

Physician to complete the following (marking dosage and prescribed additional meds):

EPINEPHRINE IS THE FIRST LINE OF TREATMENT

1. ACT IMMEDIATELY: Inject Auto-injectable Epinephrine in thigh (note the time given) Physician to mark dosage.
   - EpiPen Jr. (.15mg) ____
   - EpiPen (.3 mg) _____
   - Other Auto Injectable Epinephrine _____
2. Call 911
3. After injection, lay student on back and raise legs, as respiratory status tolerates, until EMS arrives. Observe closely
4. If no improvement within 5-15 minutes, **give 2nd dose of epinephrine.**

5. Additional medications to be given: _____

IMPORTANT – ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS

_____ _____
Physician's Signature *Date*

_____ _____
Physician's Name Printed Office Phone #

I authorize the release of my child's medical information regarding the above to the school nurse at _____.

_____
Parent/Guardian Signature and Date