COLUMBUS SCHOOL DISTRICT
ANAPHYLAXIS EMERGENCY ACTION PLAN

Name: ____ **DOB:** _______________

Allergy to: ____

Asthma: ☐Yes (*high risk for severe reaction*) ☐ No

Other health problems besides anaphylaxis: ____
Concurrent medications, if any: ____

SYMPTOMS OF ANAPHYLAXIS INCLUDE:

MOUTH:	**Itching, swelling of lips and/or tongue**
THROAT:	**Itching, tightness/closure, hoarseness**
SKIN:	**Itching, hives, redness, swelling**
GUT:	**Vomiting, diarrhea, cramps**
***LUNG:**	**Shortness of breath, cough, wheeze**
***HEART:**	**Weak pulse, dizziness, passing out**

Only a few symptoms may be present. Severity of symptoms can change quickly.

****Some symptoms can be life threatening!* ACT FAST!**

WHAT TO DO:

1. INJECT EPINEPHRINE IN THIGH USING (check one): **☐ EpiPen, Jr. (0.15 mg)** **☐ Twinject (0.15 mg)**
☐ EpiPen, Jr. (0.3 mg **☐ Twinject (0.3mg)**

Other medication/dose/route:

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IMPORTANT: ASTHMA PUFFERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS!!

2. CALL 911 or RESCUE SQUAD (BEFORE CALLING CONTACTS!)

3. Emergency contact #1: _________________________**Home** ____________**work** ____________**cell**___________

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DO NOT HESITATE TO GIVE EPINEPHRINE!

COMMENTS: ____

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______________________ / __________	______________________ / __________	______________________ / __________
Physician's Signature **Date**	**Parent Signature** **Date**	**School Nurse Signature** **Date**

Adapted from J. Allergy Clin Immunol 1998; 102:173-176 and J Allergy Clin Immunol 2006; 117:367-377