NOTRE DAME HIGH SCHOOL

Member of the Middle States Association of Colleges and Secondary Schools

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ANAPHYLAXIS for Food or other Allergens HEALTH PLAN

Student: _____Gr/Teacher: _____DOB/Age: _____

Emergency Contact #1: _____ _____ _____
Name Relationship Phone

Emergency Contact #2: _____ _____ _____
Name Relationship Phone

Physician's name: _____ Phone: _____

Allergy to: _____

Weight: _____.lbs Asthma ___Yes ___No (higher risk for sever reaction)

ASSESSMENT DATA: (fill-in and check if applicable)

Signs/Symptoms	Triggers	First Aid Interventions
__ __ __ __ __Other_____ _____ _____	__ __ __ __ __ __ Other_____ _____ _____	___ ___ ___ ___ ___ _ Other_____ _____ _____

Frequency of episodes: _____ Number of hospitalizations in past 12 months: _____

Current medications: (home (h) and school (s), including OTC and alternative meds)

Name	Route	Dose	Frequency

For self-carry Medications:

- ☐ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that he/she **SHOULD NOT** be allowed to carry and use that medication by him/herself.
- ☐ It is my opinion that _____ **SHOULD** carry his/her medication by him/herself.
    1. Student knows action of the medication and reason for taking medication.
    2. Student is aware of possible side effects of medication.
    3. Student agrees to never share medication with anyone.
    4. Student will always carry medication in correct container.
    5. Student agrees to go to the nurse's office if symptoms are not relieved by medication or if student has to use the medication more than twice in a day.

If any of the above conditions are not met, student will forfeit the right to carry and self-administer medication.

ANAPHYLAXIS **EMERGENCY** ACTION PLAN

Student: _____DOB/Age: _____

Emergency action is necessary when the student has any of the following…

SEVERE SYMPTOMS:

- MOUTH – Itching, swelling of lips and/or tongue
- THROAT – itching, tightness/closure, hoarseness, trouble swallowing
- SKIN - itching, hives, redness, swelling
- GUT – vomiting, diarrhea, cramps
- LUNGS – shortness of breath, cough, wheeze
- HEART – pale, faint, weak pulse, dizziness, passing out
- OTHER – feeling something bad is about to happen, anxiety, confusion

This is a LIFE-THREATING reaction DO NOT WAIT...

GIVE Epinephrine NOW AND CALL 911.	**GIVE THESE MEDICINES NOW AND CALL 911.**
• Medicine_____	• Medicine_____
• Dosage_____	• Dosage_____
• Route_____	• Route_____
• Frequency_____	• Frequency_____
• Other_____	• Other_____

Note: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. Use Epinephrine.

Special instructions:

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. **CALL 911. Request ambulance with epinephrine.**

- ☐ Consider giving additional medications (following or with the epinephrine)
  - o Antihistamine
  - o Inhaler (bronchodilator) if asthma
- ☐ Lay the student flat, raise legs and keep warm. If breathing is difficult or they are vomiting let them sit-up or lie on their side.
- ☐ If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- ☐ Alert emergency contacts.
- ☐ Transport student to ER even if symptoms resolve. Student should remain in ER for 4 + hours because symptoms may return.
- ☐ Other_____

MILD SYMPTOMS: WHEN IN DOUBT, GIVE EPINEPHRINE

- ☐ If checked, give Epinephrine immediately for **ANY** symptoms if the allergen was likely eaten.
  - NOSE – itchy/runny nose, sneezing
  - MOUTH – itchy mouth
  - SKIN – a few hives, mild itch
  - GUT – mild nausea/discomfort

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student, alert emergency contacts
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE**

Physician's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Student's Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____