School District of South Orange-Maplewood
Anaphylaxis Emergency Health Care Plan

Student's Name: DOB: School: South Mountain Annex Teacher: Gr

ALLERGY TO: _____

Asthmatic Yes*_____ No_____ *Higher Risk for Severe Reaction

Location Of Auto Injector:_____

DESIGNEES MAY ONLY ADMINISTER EPINEPHRINE VIA AN AUTO INJECTOR

STEP 1: TREATMENT

Symptoms:	**Administer Checked Medication**** ** To be determined by physician authorizing treatment
■ If a food allergen has been ingested, but *no symptoms:*	☐ Epinephrine ☐ Antihistamine
■ Mouth - Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
■ Skin - Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
■ Gut - Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
■ Throat -Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
■ Lung - Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
■ Heart - Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
■ Other _____	☐ Epinephrine ☐ Antihistamine
■ **If reaction is progressing (several of the above areas affected), administer:**	☐ Epinephrine ☐ Antihistamine

➔ **Use District Forms for Medication Orders**

STEP 2: EMERGENCY CALLS

1. **CALL 911!! State that an allergic reaction has been treated, and additional epinephrine may be needed.**
2. Call Dr._____ Phone Number _____
3. Call Parent/Guardian_____ Phone Number(s)_____
   Phone Number _____
4. Emergency Contacts: Name/Relationship
   a. _____ Phone Number _____
   b. _____ Phone Number _____

Parent/Guardian's Signature _____ **Date** _____

Physician's Signature _____ **Date** _____
(Required)

TRAINED STAFF MEMBERS

1. _____ Room _____Ext _____
2. _____ Room _____ Ext _____
3. _____ Room _____ Ext _____