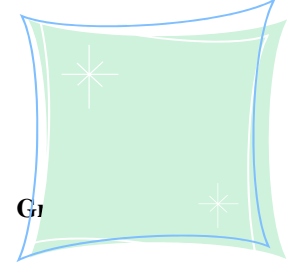


**School District of South Orange-Maplewood
Anaphylaxis Emergency Health Care Plan**

G1



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

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

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