ACTION PLAN FOR ANAPHYLAXIS

Patient's Name		Date of Birth	Expiration Date for Action Plan
Health Care Provider		**Provider's Phone Number**	
Responsible Person (i.e. parent/guardian)		**Phone Number**	
Emergency Contacts	**Home Telephone Number**	**Work Number**	**Cellular Number**
1.			
2.			
Patient's known severe allergies:			

WATCH FOR SIGNS AND SYMPTOMS OF ANAPHYLAXIS

Medication:

To prevent anaphylaxis shock administer a one time injection in thigh or specify other location

_____

☐ EpiPen Jr. (0.15 mg)

☐ EpiPen (0.3 mg)

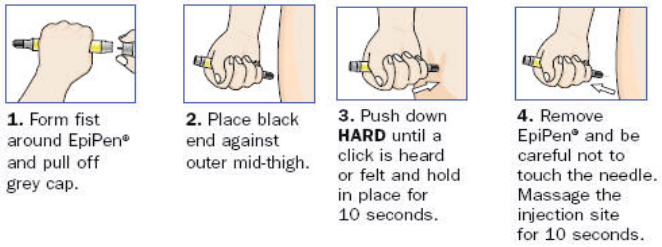
☐ Other _____

Only a few signs and symptoms may be present. Severity of symptoms can change quickly. Some symptoms can be life threatening:

- **Rash (especially hives) with redness and swelling especially on face, lips and tongue**
- **Shortness of breath, cough, wheeze**
- **Difficulty talking and/or hoarse voice**
- **Abdominal pain, vomiting, diarrhea**
- **Loss of consciousness**

ACT QUICKLY !!!!!

How to give EpiPen® or EpiPen® Jr (can be administered through clothing)



1. Form fist around EpiPen® and pull off grey cap.
2. Place black end against outer mid-thigh.
3. Push down **HARD** until a click is heard or felt and hold in place for 10 seconds.
4. Remove EpiPen® and be careful not to touch the needle. Massage the injection site for 10 seconds.

1. **Stay with the child and have someone call 911.**
2. **Locate EpiPen (epinephrine).**
3. **Oversee or assist child in injecting the epinephrine in thigh using medication listed above.**
4. **Contact responsible person or other emergency contacts listed above.**

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN AND YOUTH:

Healthcare Providers Initials

_____This student was trained and is capable to self-administer with the auto injectable epinephrine pen

_____This student is not approved to self-medicate

_____ _____

Health Care Provider's Signature **Date**

☐ As the Responsible Person, I hereby authorize a trained school employee to administer medication to the student

☐ As the Responsible Person, I hereby authorize this student to possess and self-administer medication.

I hereby acknowledge that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under D.C. Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct

This publication was supported by Cooperative Agreement Number U59/CCU324208-03 from the Centers for Disease Control and Prevention (CDC). Its content is solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

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DOH
DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

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Responsible Person's Signature Date

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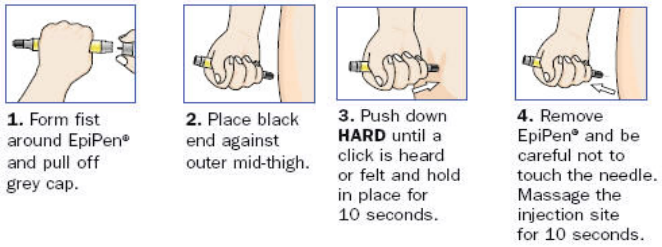

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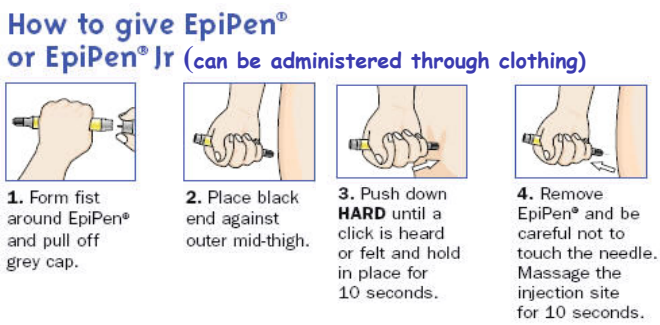

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