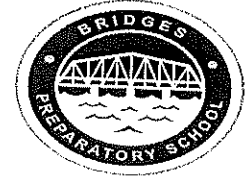


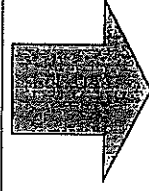
Severe Allergy/Anaphylaxis Action Plan and Treatment Authorization



Name: _____ DOB: _____
 Teacher: _____ Grade: _____
 Allergy to: _____

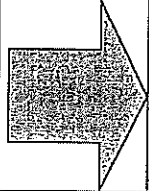
Asthma: Yes: _____ No: _____ (higher risk for a severe reaction) Weight: _____ lbs _____ kg

RECOGNIZE SEVERE ANAPHYLAXIS SYMPTOMS:
 LUNG: shortness of breath, wheezing, repetitive cough
 Heart: Pale, blue, faint, weak pulse, dizzy, confused
 THROAT: tight, hoarse, trouble breathing/swallowing,
 MOUTH: Swelling of the throat, lips, tongue, metallic taste
 SKIN: generalized flushing or itching, hives (rash), swelling
 GUT: Vomiting, cramps, diarrhea, nausea
 Any **ONE** or **COMBINATION** of the above symptoms from different body areas can progress rapidly to a life threatening situation!!



INJECT EPINEPHRINE IMMEDIATELY!!
 1. Call 911
 2. Begin Monitoring
 3. Administer Rescue Inhaler if asthmatic
 4. Give additional medications
****Inhalers/Bronchodilators and antihistamines are NOT to be depended on to treat a severe reaction (anaphylaxis).
 USE EPINEPHRINE!**

MILD SYMPTOMS ONLY:
 MOUTH: Itching *without* swelling, especially seen with ingestion of fresh fruits
 SKIN: Limited redness of skin/few small hives



1. Give Antihistamine
 2. Stay with student, call parents
 3. If symptoms progress, **USE EPINEPHRINE**
 4. Begin Monitoring

_____ If checked, administer epinephrine for **ANY** symptoms if there was **possible** exposure
 _____ If checked, administer epinephrine **BEFORE** symptoms occur, if there was **known** exposure

MEDICATIONS/DOSES:

EPINEPHRINE AUTO-INJECTOR: (BRAND AND DOSE): EpiPen _____ EpiPen JR _____ Auvi-Q _____ Auvi-Q JR _____
 BRONCHODILATOR: (BRAND AND DOSE): _____
 ANTIHISTAMINE: (BRAND AND DOSE): _____
 (***) Antihistamines should NOT be used as a first line of treatment during an anaphylaxis episode. It will treat itching ONLY – it will not halt vascular collapse or swelling!!)

MONITORING: Stay with student. Alert Health Care professionals and parent. Tell rescue squad epinephrine was given and request an ambulance with epinephrine. Note time when epinephrine was administered. **A second dose of epinephrine can be administered within 5 minutes** if symptoms persist or recur. For a severe reaction consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.

____ Student may carry epinephrine ____ Student may *self-administer* epinephrine
 ____ *Classroom accommodations needed

EMERGENCY CONTACTS: 911 Rescue Squad: _____
 Parent/Guardian: _____ Phone: _____
 Name/Relationship: _____ Phone: _____

LICENSED HEALTH CARE PROVIDER (signature): _____ **Date:** _____
 Printed name of Health Care Provider: _____ Phone: _____

I hereby authorize Bridges Preparatory School staff members to take whatever action in their judgment may be necessary in providing emergency medical treatment consistent with this plan, including the administration of medication to my child. I understand that Bridges Preparatory School is protected by the SAVE Act from liability arising from actions consistent with this plan. I also hereby authorize BPS to disclose my child's protected information to teachers and other staff members involved in the care of my child to the extent necessary for the protection, prevention of an allergic reaction or emergency medical treatment of my child and for the implementation of this plan.

Parent/Guardian Signature: _____ **Date:** _____