ANAPHYLAXIS EMERGENCY PLAN

Student Name: _____

Teacher(s) Classroom (s): _____

This student has a life-threatening allergy to the following: _____

_____

Strict avoidance of the allergen(s) by the student is critical to their well-being. An anaphylactic reaction can proceed quickly and prove fatal within minutes.

Epinephrine Auto-injector(s)

☐ **EpiPen Jr® 0.15mg**	☐ **EpiPen® 0.30mg**	**MedicAlert® Identification**
☐ **Allerject ™ 0.15mg**	☐ **Allerject ™ 0.30mg**	☐ **Yes** ☐ **No**

Location(s) of Auto-injector(s): _____

☐ **Asthmatic**: Student is at greater risk. If student is having a reaction and has difficulty breathing, give epinephrine auto-injector before asthma medication.

Early recognition of symptoms and immediate treatment could save a person's life

- **A person having an anaphylactic reaction might have ANY of these signs and symptoms: Think F.A.S.T.**

  Face: itchiness, redness, rash, swelling of face and tongue
  Airway: trouble breathing, swallowing or speaking
  Stomach: stomach pain, vomiting, diarrhea
  Total Body: rash, itchiness, swelling, weakness, paleness, sense of doom, loss of consciousness

A.C.T. quickly. The first signs of a reaction can be mild, but symptoms can get worse very quickly.

1. **Administer epinephrine** auto-injector at the first sign of a reaction occurring in conjunction with a known or suspected contact with an allergen. Give second dose in 10-15 minutes or sooner **IF** the reaction continues or worsens.
2. **Call 911**. Tell them someone is having a serious allergic reaction/anaphylactic.
3. **Transport to hospital** by ambulance even if symptoms are mild or have stopped.
4. **Call the parent(s)/guardian(s)/emergency contact.**

PHYSICIAN INSTRUCTIONS

Student Name:_____

Parent(s)/Guardian(s) Name:_____

Address: Street_____

City_____ **Postal Code**_____

1) **Does this patient have a known predisposition to anaphalaxis** _____**?**

2) **What medication is to be administered in the event of an anaphylactic reaction?**

Name of Medication _____

Dose or amount to be given: _____

Total doses or times per event: _____

Additional Instructions:_____

_____

Prescribing Physician Name: **Signature:**

Physician's Address **City** **Postal Code** **Phone**

PRE-AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

I hereby pre-authorize and give permission for, Sinclair Secondary School **to administer medication to my child in the event of an anaphylactic reaction, according to the Board's policies and procedures and the physician's prescription and instructions as described within this individual student plan.**

Parent(s)/Guardian(s) Signature **Date**

Student's Signature **Date**

*****This form expires June 30 every year and must be renewed every September.**
*****It is recommended that students carry an epi-pen as well as one being kept in the school office.**