

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)

<input type="checkbox"/> EpiPen Jr® 0.15mg	<input type="checkbox"/> EpiPen® 0.30mg	MedicAlert® Identification <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Allerject™ 0.15mg	<input type="checkbox"/> Allerject™ 0.30mg	

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. **Addminister 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.