

Western School Corporation
PLAN OF CARE- SEVERE ALLERGY
(Must be completed by Physician)

Name: _____ Grade _____ Age _____
Last name First MI

School Building: _____

Parent /Guardian Name: _____ Phone (H) _____

Address: _____ Phone (W) _____

Emergency Phone Contact #1: _____
Name Relationship Phone

Emergency Phone Contact #2 _____
Name Relationship Phone

Physician Student Sees for Allergy: _____
Phone

Other Physician: _____
Phone

ALLERGIES: (Please list your child's allergies and symptoms)

Has your child had a reaction before? _____ Please list the date, symptoms, and treatment of episode:

◆ Step 1: TREATMENT ◆

Symptoms:	Give Checked Medications: <small>(To be determined by physician authorizing treatment)</small>
• 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), give:	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine

*Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine:

Inject intramuscularly (circle one) EpiPen® EpiPen®Jr. Twinject® 0.3 mg Twinject® 0.15 mg
 (see reverse side for directions)

Antihistamine: give _____
Medication/Dose/Route

Other: give _____
Medication/Dose/Route

◆Step 2: EMERGENCY CALLS◆

1. Call 911 if epinephrine given. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Parent.

EVEN IF PARENT CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!!


Parent/Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____

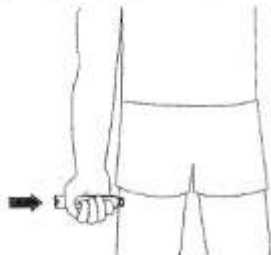
(Required)

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions


- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)




- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds




DEY® and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions




Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.




SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.



Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.



Once EpiPen® Twinject® is used, call the Rescue Squad. Take the used unit with you to the ER. Plan to stay for observation at ER for at least 4 hours.

This form was modeled after the Food Allergy and Anaphylaxis Network action plan.

