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| **Non-Food Allergy Anaphylaxis Emergency Care Plan** |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O. B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergy to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_\_lbs Asthma [ ] Yes (higher risk for a severe reaction) [ ] No

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| **FOR ANY OF THE FOLLOWING**  **SEVERE SYMPTOMS:**  **LUNG**: Shortness of breath, wheeze, cough  **HEART**: Pale, blue, faint, weak pulse,  dizziness,  **THROAT:** Tightness, hoarseness, itchiness,  trouble breathing or swallowing  **MOUTH**: Swelling of the lips/tongue,  itchiness  **SKIN**: Itchiness, hives, redness, swelling  **GUT**: Vomiting, diarrhea, cramps  **OTHER**: feeling bad something is about to  happen, anxiety  **DO NOT DEPEND ON ANTIHISTAMINES OR INHALERS TO TREAT A SEVERE REACTION. USE EPINEPHRINE**   1. INJECT EPINEPHRINE IMMEDIATELY 2. CALL 911 AND REQUEST AN   AMBULENCE WITH EPINEPHRINE   1. CONSIDER GIVING ADDITIONAL MEDS (ANTIHISTAMINE/INHALER) 2. LAY THE STUDENT FLAT AND RAISE LEGS. IF HAVING TROUBLE BREATHING OR THERE IS VOMITTING PLACE ON LEFT SIDE 3. IF SYMPTOMS DO NOT IMPROVE OR RETURN, GIVE ANOTHER DOSE OF EPINEPHRINE (MUST BE AT LEAST 5 MINS FROM THE FIRTST DOSE) 4. ALERT EMERGENCY CONTACTS 5. TRANSPORT TO AN ER (EVEN IF THERE IS IMPROVEMENT) | **FOR ANY OF THE FOLLOWING**  **MILD SYMPTOMS:**  **NOSE:** Itchy/runny nose, sneezing  **MOUTH:** Itchy mouth  **SKIN:** A few hives, mild itch  **GUT:** Mild nausea/discomfort   1. GIVE ANTIHISTAMINES, IF ORDERED BY MD 2. STAY WITH STUDENT; ALERT EMERGENCY CONTACTS 3. WATCH STUDENT CLOSELY FOR CHANGES. IF SYMPTOMS WORSEN, GIVE EPINEPHRINE   **NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE** |
| **MEDICATION/DOSES**  Epinephrine Brand\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Epinephrine Dose: [ ] 0.15mg [ ] 0.30mg  Antihistamine Brand or Generic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Antihistamine Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other (inhaler-bronchodilator\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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Parent/Guardian Signature Date Physician Signature Date

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