HENRY COUNTY PUBLIC SCHOOLS

P. O. Box 8958
3300 Kings Mountain Road
Collinsville, VA 24078-8958
(276) 634-4700
Fax: (276) 638-2925
www.henry.k12.va.us

Anaphylaxis Emergency Action Plan

Student's Name: (First, MI, Last)	Date of Birth:	School name:
Health Care Provider:	Provider's phone #:	Provider's fax #:
Emergency Contact's Name and number:	Emergency Contact's name and number:	Allergies:

Medical Diagnosis: _____

Medications: _____

Symptoms of Anaphylaxis: ***Only a few symptoms may be present. Severity of symptoms can change quickly. *Some symptoms can be life-threatening. ACT FAST!***

- **MOUTH itching, swelling of lips and/or tongue**
- **THROAT* itching, tightness/closure, hoarseness**
- **SKIN itching, hives, redness, swelling**
- **GUT vomiting, diarrhea, cramps**
- **LUNG* shortness of breath, cough, wheeze**
- **HEART* weak pulse, dizziness, passing out**

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

- **Inject epinephrine in thigh using (check one): *Please note the time and location of the injection**
  - **Adrenaclick (0.15 mg) ____ Auvi-Q (0.15 mg)____ EpiPen Jr (0.15 mg)____**
  - **Adrenaclick (0.3 mg) ____ Auvi-Q (0.3 mg) ____ EpiPen (0.3 mg) ____**
  - **Epinephrine Injection, USP Auto-injector- authorized generic (0.15 mg) ___ (0.3 mg) ____**
  - **Other (0.15 mg) ____ Other (0.3 mg) ____**
- **Call or have a bystander call 911 immediately or activate the Emergency Medical System (EMS).**
  - **Explain to the 911 operator that anaphylaxis is suspected and epinephrine has been given.**
- **Keep the student either lying down or seated, never leave alone. If they lose consciousness, check if they are breathing and have a pulse. If not, begin CPR (cardiopulmonary resuscitation),**
- **call out for help and continue CPR until the individual regains a pulse and is breathing or until EMS arrives and takes over.**
- **Repeat the dose after 5 to 15 minutes if no improvement, symptoms persist or return.**
- **Stay with the student until EMS arrives, continuing to follow the directions above**
- **Provide EMS with epinephrine auto injector labeled with name, date, and time administered to transport to the ER with the student. Use caution: auto injector needle does not retract.**

I give permission for school personnel to follow this plan, administer medication and care for my child, and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/ monitoring devices. I approve this Asthma Management Plan for my child. With HCP authorization & parent consent inhaler will be located in ___ clinic or ___ with student (self-carry) **PARENT/Guardian** _____ **Date**_____	**To be completed by the provider:** _____Student may carry and self-administer epi-pen at school. _____Student needs supervision/assistance with the Epi-pen. Provider SIGNATURE:_____ DATE _____

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