## 2023-2024 School Year

## Dover-Eyota Public Schools Anaphylaxis Emergency Action Plan

***♦ AEAP must be updated each year or if the participant’s diagnosis changes ♦***

Student’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Teacher:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGY TO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place

Child’s

Picture

Here

Asthmatic Yes\* No \*Higher risk for severe reaction

**♦ TREATMENT♦**

**MUST BE COMPLETED BY THE physician authorizing**

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| **PART 1: PARTICIPANT INFORMATION - PLEASE PRINT** |

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| **Symptoms** | **Check Medication** | |
| If a food allergen has been ingested, but *no symptoms:* | * Epinephrine | * Antihistamine |
| Mouth - Itching, tingling, or swelling of lips, tongue, mouth | * Epinephrine | * Antihistamine |
| Skin - Hives, itchy rash, swelling of the face or extremities | * Epinephrine | * Antihistamine |
| Gut - Nausea, abdominal cramps, vomiting, diarrhea | * Epinephrine | * Antihistamine |
| Throat\*- Tightening of throat, hoarseness, hacking cough | * Epinephrine | * Antihistamine |
| Lung\*- Shortness of breath, repetitive coughing, wheezing | * Epinephrine | * Antihistamine |
| Heart\*- Weak or thready pulse, low blood pressure, fainting, pale, blueness | * Epinephrine | * Antihistamine |
| Other\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Epinephrine | * Antihistamine |
| If reaction is progressing (several of the above areas affected), give: | * Epinephrine | * Antihistamine |

** EpiPen® EpiPen® Jr.**  **Twinject® 0.3 mg**  **Twinject® 0.15 mg**

Antihistamine: give\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

medication/dose/route

Other:give­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

medication/dose/route

**Doctor’s Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

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| **PART 2: DOSAGE Epinephrine: inject intramuscularly (Check One)** |

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| **♦ Staff Anaphylaxis Emergency Plan of Action ♦**  \*\* Potentially life-threatening. The severity of symptoms can quickly change \*\* |
| 1. Notify the health office and classroom teacher immediately and they will retrieve the Epi-pen(s) |
| 1. Administer epi-pen immediately as instructed and continue to monitor student |
| 1. Call must be placed to 911 to request an ambulance. Specify that student is having an anaphylactic reaction. |
| 1. Administer 2nd epi-pen dose if symptoms start to worsen again after 20 minutes and if the ambulance has not yet arrived. |
| 1. Contact parents:   NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **♦ Parent and Student Consent to Carry/Self-Administer Epi Pen** **♦**  **♦♦ *optional* ♦♦**  ***Self-Administration of Medication*** |
| 1. I hereby authorize my student to self-administer and carry the epinephrine emergency medication while attending school or school functions as prescribed by the physician. |
| 1. My student will have been instructed by the parent or guardian and demonstrates the knowledge and skills to be able to self-administer the drug correctly. |
| 1. I understand that my student will carry this medication at and to/from school and it's placement and handling will not be monitored by school personnel. |
| 1. I will provide an additional pen to be kept in the health office at all times, in case the student is not carrying or is unable to use it. |
| 1. The student will not allow anyone else to use or possibly tamper with the medication. |
| 1. The right to self-carry this medication may be revoked if not carried appropriately. |
| 1. I understand that trained personnel (classroom teachers, paraprofessionals, health office staff, and office staff) will follow the Anaphylaxis Emergency Health plan as completed by the physician, should the student be unable to self-administer their medication. |
| 1. *Your signature below indicates your agreement to the above guidelines and authorizes your student to self-carry their epi-pen while at school.*   Student  Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |