Great Meadows Regional School District
ANAPHYLAXIS ACTION PLAN

Patient Name: _____DOB: _____Grade/teacher: _____

Diagnosis: [ ] Food allergy Please specify: _____
[ ] Bee sting allergy
[ ] Other Please specify: _____

Symptoms: Please circle any symptoms that have been evident in past reactions:
MOUTH: Itching and swelling of the lips, tongue or mouth
THROAT: Itching and/or sense of tightness in the throat, hoarseness and hacking cough
SKIN: Hives, itchy rash and/or swelling about the face or extremities, sweating, flushing or pallor
STOMACH: Nausea, abdominal cramps, vomiting and/or diarrhea
LUNG: Shortness of breath, repetitive coughing and/or wheezing, tightness of chest
HEART: "Thready pulse", fainting

Epinephrine Administration:
Check one:
[ ] EpiPen/Auvi-Q IM lateral aspect of thigh and call EMS ***OR***
[ ] EpiPen Jr./Auvi- Q Jr. IM lateral aspect of thigh and call EMS

AND

Check one:
[ ] Administer epinephrine immediately if exposure to trigger is suspected ***OR***
[ ] Administer epinephrine if the following symptoms are present: _____

_____

[ ] May repeat dose in 15 minutes if symptoms continue and EMS has not arrived

Self-Administration:
[ ] I have instructed the above student in the proper administration of the EpiPen. It is my opinion that he/she is capable of self-administration. Student must notify teacher or School Nurse when he/she has used the EpiPen. The EpiPen should be [ ] in the possession of the student
[ ] stored in the health office

OR

[ ] It is my opinion that the above student **is not** capable of self-administration. If possible, the school nurse should delegate EpiPen administration to another staff member in the event of the absence of the nurse.

Other Medications: Please list any other medications to be given in the event of an anaphylactic reaction. ***Please note that by law in New Jersey only the administration of Epinephrine can be delegated***.

Medication and Dose: _____

Date: _____Physician's Name (please print or stamp): _____

Physician's Signature: _____

To Be Completed By the Parent/Guardian

I request that the school nurse administer the medication(s) listed above. I relieve the board and its employees of liability for the administration of medication.

_____ _____
Date Signature of Parent/Guardian