



# Merrill Area Public Schools

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**\* Student Achievement \* Community Partnership \* Future Success \***

## ANAPHYLAXIS ACTION PLAN

School Year: 2023-2024

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

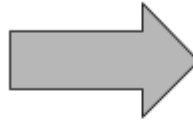
To be completed by practitioner:

Allergic to: \_\_\_\_\_

Asthma  Yes  No

For ANY of the following **SEVERE SYMPTOMS**:

- LUNG:** Short of breath, wheeze, repetitive cough
- HEART:** Pale, blue, faint, weak pulse, dizzy, confused
- THROAT:** Tight, hoarse, trouble breathing/swallowing
- MOUTH:** Obstructive swelling (tongue and/or lips)
- SKIN:** Hives, itchy rashes, swelling (e.g., eyes, lips)
- GUT:** Vomiting, diarrhea, cramps



**1. INJECT EPINEPHRINE IMMEDIATELY!**

Medication: \_\_\_\_\_

Dose: \_\_\_\_\_

- 2. **Call 911.** Note time epinephrine was given.
- 3. Keep student calm and seated.
- 4. Monitor student's condition and provide first aid if necessary.

5. **If symptoms don't improve within \_\_\_\_\_ minutes, give second dose of Epinephrine (if available).**

6. Additional medicine (if any):

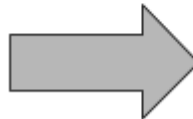
Medication: \_\_\_\_\_

Dose: \_\_\_\_\_

*Severity of symptoms can change quickly. \*Some symptoms can be life-threatening. ACT FAST!*

For **MILD SYMPTOMS ONLY**:

- MOUTH:** Itchy mouth
- SKIN:** A few hives around mouth/face, mild itch
- GUT:** Mild nausea/discomfort



**1. Administer antihistamine\***

Medication \_\_\_\_\_

Dose \_\_\_\_\_

2. Additional medicine if any:

Dose \_\_\_\_\_

3. Stay with student and monitor symptoms.

4. **If symptoms don't improve or get worse move on to Severe Symptom treatment.**

5. Call parent and School Nurse

**IF MORE THAN ONE MILD SYMPTOM, GIVE EPINEPHRINE.**

\*Antihistamines such as loratadine, fexofenadine, and cetirizine are not considered fast-acting medications and are not appropriate for early treatment of possible anaphylaxis.

**YES**  **NO** Student understands anaphylaxis AND has successfully demonstrated epinephrine delivery. Student may self-carry epinephrine device while at school and during school sponsored events.

**ALL STUDENT'S EMERGENCY MEDICATIONS MUST BE EASILY ACCESSIBLE AT ALL TIMES. EMERGENCY MEDICATIONS MUST ACCOMPANY STUDENT ON ALL TRIPS AWAY FROM THE BUILDING.**

To be completed by parent/guardian:

**YES**  **NO** My student needs to sit at an allergy aware table for lunch.

**YES**  **NO** Contact me for directions on special occasion treats; I will also supply a safe snack box.  **YES**  **NO** My student may eat treats with wording such as "may contain, processed in a facility or made on shared equipment."

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

I hereby give permission to staff designated by the school principal or nurse to give the above medication to my student according to the instructions stated above and authorize them to contact the practitioner, if necessary.

**PRACTITIONER SIGNATURE** \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

Practitioner signature directs the above medication administration and indicates willingness to communicate with school staff regarding this medication.