



Pasco County Schools

# Anaphylaxis Medical Management Plan

<b>Student Name:</b>	<b>D.O.B:</b>	<b>School Year:</b>
<b>Allergy to:</b>	Asthma: _____ Yes <i>*higher risk for severe reaction</i> _____ No	
<b>Other health problems besides anaphylaxis</b>	<b>Other medications:</b>	

## Symptoms of Anaphylaxis

<b>Mouth</b>	Itching, swelling of lips and/or tongue
<b>Throat*</b>	Itching, tightness/closure, hoarseness
<b>Skin</b>	Itching, hives, redness, swelling
<b>GI:</b>	Vomiting, diarrhea, cramps
<b>Lung*</b>	Shortness of breath, cough, wheeze
<b>Heart*</b>	Weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.

**\*Some symptoms can be life threatening. ACT FAST!**

## Emergency Action Steps

### DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):

_____ Epi-pen Jr. (0.15 mg.)	_____ Epi-pen (0.3 mg.)
_____ Adrenaclick (0.15 mg.)	_____ Adrenaclick (0.3 mg.)
_____ Auvi-Q (0.15 mg.)	_____ Auvi-Q (0.3 mg.)
_____ Epinephrine injection, USP Auto-injector – authorized generic	
_____ (0.15 mg.)	_____ (0.3 mg.)

Other (specify): \_\_\_\_\_

**ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS!**

2. Call 911 immediately! Call emergency contacts next.

3. Emergency contact #1: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

Emergency contact #2: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

**Parent has provided emergency medication to school:  YES  NO**

I hereby authorize the above named physician and Pasco County Schools staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parent.

Print, type, or stamp Physician's Name & Information: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Adapted from American Academy of Allergy, Asthma & Immunology www.aaaai.org.*