Washington International School
3100 Macomb Street NW • Washington, DC 20008
MS/US Nurse 202.495.7301 • PS Nurse 202.243.1709

Anaphylaxis Action Plan

Name____

STUDENT PHOTO

ALLERGENS TO AVOID	**ASTHMA**
______________________________	☐ YES
______________________________	☐ NO

Mild to Moderate Allergic Reaction

1. Stay Calm 2. Stay with Student & Call for Help 3. Locate EpiPen®

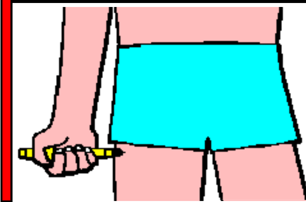
SYMPTOMS	
• SWELLING OF LIPS, FACE OR EYES	☐ **Give Antihistamine** ______________________
• HIVES OR WELTS	______________________________
• ABDOMINAL PAIN,	☐ **Give EpiPen®** ☐ **Give EpiPen Jr.**
• VOMITING, TINGLING IN MOUTH	☐ **Give Twinject 0.3 mg** ☐ **Give Twinject 0.15mg**

Watch for any one of the following symptoms of Anaphylaxis

ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

1. Stay Calm 2. Give Epinepherine 3. CALL "911"

SYMPTOMS	**EpiPen® or Twinject administered immediately. Repeat every _____ minutes until the ambulance arrives.**
• DIFFICUL/NOISY BREATHING • SWELLING OF TONGUE • WHEEZING OR PERSISTENT COUGH • DIFFICULTY SPEAKING OR HOARSE VOICE • LOSS OF CONSCIOUSNESS • PALE/FLOPPY (young children)	Additional instructions include: ______________________________ ______________________________



- Stay with child and have someone call 911
- Locate EpiPen® or Twinject and assist or administer
- Form fist around EpiPen® or Twinject and pull off cap
- Place black end against outer mid-thigh
- Push down HARD until CLICK is heard. Hold for **10 seconds**
- Contact responsible person/emergency contacts listed

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH AS REQUIRED BY DC LAW A17-107, STUDENT ACCESS TO TREATMENT ACT OF 2007

Healthcare Provider Initials:

______ This student is capable and approved to self-administer an auto injector epinephrine pen.

_______ This student is **not** approved to self-medicate**.**

Provider Signature_______________________________ **Date**__________

Provider Address_______________________________ Phone__________

As the Responsible Person:

______ I hereby authorize a trained school employee to administer medication to the student.

______ I hereby authorize the student to possess and self-administer auto injectable epinephrine.

______ I understand that this student is **not** authorized to self-administer injectable epinephrine.

I agree that the school and its employees shall incur no liability and shall be held harmless against any claims that may arise relating to the administration, supervision, training, or self-administration of medication.

Parent Signature_______________________________ **Date** __________

Adapted from the DC Department of Health and ASCIA