



PLACE
PICTURE
HERE

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Short of breath,
wheezing,
repetitive cough



HEART

Pale, blue,
faint, weak
pulse; dizzy



THROAT

Tight, hoarse,
trouble
breathing/
swallowing



MOUTH

Significant
swelling of the
tongue and/or lips



SKIN

Many hives over
body, widespread
redness



GUT

Repetitive
vomiting, severe
diarrhea



OTHER

Feeling
something bad is
about to happen,
anxiety, confusion

OR A
COMBINATION
of symptoms
from different
body areas.



- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy/runny
nose,
sneezing



MOUTH

Itchy mouth



SKIN

A few hives,
mild itch



GUT

Mild nausea/
discomfort

FOR **MILD SYMPTOMS FROM MORE THAN ONE**
SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS FROM A SINGLE SYSTEM**
AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

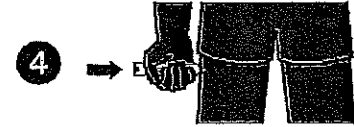
PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE



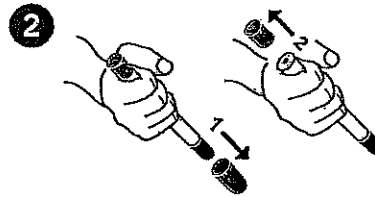
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Blank space for writing other directions or information.

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE



Auto-Injectable Epinephrine Plan

School _____

School Year _____

Date _____

Student Name: _____ Date of Birth: _____

Teacher: _____ Grade Level: _____

Parents/Guardians: _____

Home Phone: _____ Work Phone (Mother): _____

Cell Phone: _____ Work Phone (Father): _____

Emergency Contact: _____

Name Relationship

Phone

Physician: _____ Phone: _____

I understand that it is my responsibility as the parent/guardian of _____ ("Student") to notify the school nurse/medical professional or designee of any changes in my child's health condition and/or medication/treatment regimen. As parent or legal guardian of the above named student, I understand that my signature on this document authorizes representatives of Henry County Schools to communicate about/receive information regarding my child/ward from my child's physician and his/her staff. I understand that this health information will only be shared with pertinent school staff.

By signing below, I acknowledge that I have read, understood, and agree to the terms of Henry County Schools' Auto-Injectable Policy. I authorize Henry County Schools, its employees, and agents to seek medical treatment for my child, if at their discretion, they deem such medical treatment is necessary and appropriate. By signing this Auto-Injectable Epinephrine Plan, I release Henry County Schools, its employees, and agents from all civil liability including but not limited to issues pertaining to the Student's self-administering auto-injectable epinephrine, storage and security of auto-injectable epinephrine, and the decision of Henry County Schools' employees and agents to administer or not to administer auto-injectable epinephrine.

Parent/Guardian Signature _____

Date _____

Completed by Physician (Attach additional pages if necessary)

Medical History:

Medical Diagnosis	Chronic/Acute	Severity	Prognosis

Description of Medical Condition (symptoms, behaviors, etc):

Medication Regimen:

Medication Name	Dosage(Amount)	When to Use

Treatment Regimen/Emergency Services:

Individual Considerations (Please indicate any special diet, physical activity limitations/adaptations, prosthetic devices, special procedures/interventions, and/or impact on school attendance):

Physician Printed Name _____

Physician Signature _____

Date _____

