

ANDERSON UNION HIGH SCHOOL DISTRICT
Anaphylaxis Emergency Action Plan
(Give a copy of this form to each of the student's teachers)

Name _____ School _____

Date of birth _____ Parent/guardian _____

Home phone _____ Work phone _____

Emergency contacts:

(Name/relationship) (Phone) (Second phone)

1. _____

2. _____

3. _____

Student's anaphylaxis (severe allergic reaction) triggers are:

Peanuts Fish
 Tree nuts Food additives (list): _____
 Milk Insect stings (list): _____
 All dairy Medications (list): _____
 Eggs Others (list): _____
 Shellfish

Student's Life threatening anaphylaxis symptoms are usually:

Swelling (eyes, lips, face, tongue) Flushed face or body
 Vomiting Dizziness, confusion
 Difficulty breathing or swallowing Fainting or loss of consciousness
 Coughing or choking Change of voice, wheezing
 Cold, clammy, sweaty skin Stomach cramps, diarrhea
 Others (list): _____

Does child wear an identifying tag or bracelet alerting others regarding possible allergic reactions?

Yes No

My child is at **higher risk** because of Asthma

Yes No

Does child have an **Emergency Medication Order** for above checked symptoms?

Yes (see attached physician order) No

CALL FOR EMERGENCY MEDICAL HELP (911) and tell the dispatcher that a child is having a life-threatening anaphylactic reaction.

Parent Signature _____

Date _____