CALDWELL-WEST CALDWELL PUBLIC SCHOOLS
EMERGENCY PLAN & MEDICATION ORDER FOR ACUTE ALLERGIC REACTION/ANAPHYLAXIS

STUDENT NAME: _____ **AGE:** _____ **GRADE:** _____

EPIPEN LOCATION: _____

TO BE COMPLETED BY PHYSICIAN:

My patient, _____ has a (please circle) **DOCUMENTED** or **SUSPECTED**

ALLERGY TO: _____

Last significant allergic reaction (date and type): _____

Is the student **Asthmatic**? (please circle): NO **YES**

SIGNS & SYMPTOMS OF ALLERGIC REACTION THAT SHOULD BE NOTED FOR THIS STUDENT:

_____

_____

MEDICATION (DOSES): _____

_____

Possible side effects: _____

EMERGENCY TREATMENT PLAN:

SYMPTOMS:		**GIVE MEDICATION CHECKED "X":**
MOUTH	Itching, tingling or swelling of the lips, tongue, mouth	☐ Antihistamine ☐ Epinephrine
SKIN	Hives, swelling on face and extremities, itchy rash	☐ Antihistamine ☐ Epinephrine
GUT	Nausea, abdominal cramps, vomiting, diarrhea	☐ Antihistamine ☐ Epinephrine
THROAT	Tightening of throat, hoarseness, hacking cough	☐ Antihistamine ☐ Epinephrine
LUNG	Shortness of breath, repetitive cough, wheezing	☐ Antihistamine ☐ Epinephrine
HEART	Thready pulse, passing out, fainting, pale, blueness	☐ Antihistamine ☐ Epinephrine
GENERAL	Panic, sudden fatigue, chills, fear of impending doom	☐ Antihistamine ☐ Epinephrine
IF A FOOD HAS BEEN INGESTED, BUT *NO SYMPTOMS*:		☐ Antihistamine ☐ Epinephrine
IF A REACTION IS PROGRESSING (SEVERAL OF THE ABOVE AREAS AFFECTED):		☐ Antihistamine ☐ Epinephrine

Antihistamine = _____ Epinephrine = _____

ADDITIONAL INSTRUCTIONS: _____

_____

_____

THE STUDENT MAY SELF-ADMINISTER THE EPINEPHRINE (PLEASE CIRCLE): NO YES

IF YES, HAS THIS STUDENT BEEN TRAINED IN THE SELF-ADMINISTRATION OF EPINEPHRINE: NO YES

PHYSICIAN NAME: _____ PHONE NUMBER: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Revised 4/16