



## Anaphylaxis Action Plan

In your application, you designated that your child has an anaphylactic allergy. To help ensure we're ready in case of emergency, we require a copy of your child's "Anaphylaxis Action Plan."

Please upload *either* a copy of your child's "Anaphylaxis Action Plan" or complete the attached "Anaphylaxis Action Plan" to the 'Parent Dashboard Forms Page'. You may also send to Roundup River Ranch either by fax at 888-524-2477 or by mail to Roundup River Ranch, C/O Camper Recruiter, 8333 Colorado River Rd., Gypsum, CO 81637.

# Allergy and Anaphylaxis Action Plan and Medication Orders

Student's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_

Place child's  
photo here

**ALLERGY TO:** \_\_\_\_\_

History: \_\_\_\_\_

Asthma:  YES (Higher risk for severe reaction)  NO

## ◇ STEP 1: TREATMENT ◇

### SEVERE SYMPTOMS:

**One or more** of the following:

LUNG: Short of breath, wheeze, repetitive cough  
HEART: Pale, blue, faint, weak pulse, dizzy, confused  
THROAT: Tight, hoarse, trouble breathing/swallowing  
MOUTH: Obstructive swelling (tongue and/or lips)  
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)  
GUT: Vomiting, crampy pain



### 1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:\*

  - Antihistamine
  - Inhaler (quick relief) if asthma

\*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE

Give epinephrine immediately if the allergen was definitely ingested, even if there are no symptoms

### MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth  
SKIN: A few hives around mouth/face, mild itch  
GUT: Mild nausea/discomfort



### 1. GIVE ANTIHISTAMINE

2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

### DOSAGE

**Epinephrine:** inject intramuscularly using auto-injector (check one):  0.3 mg  0.15 mg

Administer 2<sup>nd</sup> dose if symptoms do not improve in \_\_\_\_\_ minutes

**Antihistamine:** (brand and dose) \_\_\_\_\_

**If Asthmatic:** (brand and dose) \_\_\_\_\_

Student has been instructed and is capable of carrying and self-administering own medication.  Yes  No

Provider (print) \_\_\_\_\_ Phone Number: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

## ◇ STEP 2: EMERGENCY CALLS ◇

1. If epinephrine given, **call 911**. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.

2. Parent: \_\_\_\_\_ Phone Number: \_\_\_\_\_

3. Emergency contacts: Name/Relationship Phone Number(s)

a. \_\_\_\_\_ 1) \_\_\_\_\_ 2) \_\_\_\_\_

b. \_\_\_\_\_ 1) \_\_\_\_\_ 2) \_\_\_\_\_

### EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

To be completed by healthcare provider

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**TRAINED/DELEGATED STAFF MEMBERS**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

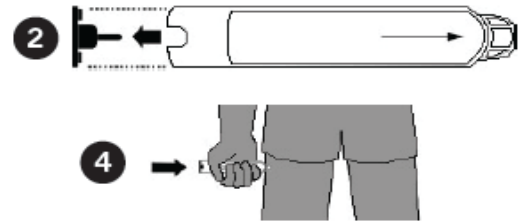
- Room \_\_\_\_\_
- Room \_\_\_\_\_
- Room \_\_\_\_\_
- Room \_\_\_\_\_
- Room \_\_\_\_\_

Self-carry contract on file.  Yes  No

Medication located in: \_\_\_\_\_

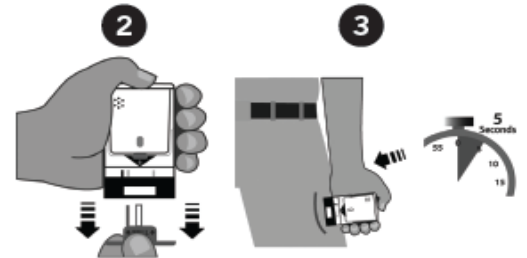
**EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS**

- 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 outer thigh.
- 4. Hold for approximately 10 seconds.
- 5. Remove and massage the area for 10 seconds.



**AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS**

- 1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
- 2. Pull off red safety guard.
- 3. Place black end against outer thigh.
- 4. Press firmly and hold for 5 seconds.
- 5. Remove from thigh.



**ADRENACLICK™/ADRENACLICK™ GENERIC DIRECTIONS**

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



**Once epinephrine is used, call 911.  
Student should remain lying down or in a comfortable position.**

Additional information: