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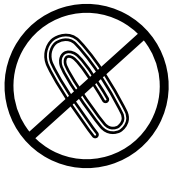
PLEASE DO NOT WRITE ABOVE THIS LINE - FOR MAGNUS HEALTH USE ONLY

Magnus Health

ANAPHYLAXIS ACTION PLAN FORM

This coversheet is **ONLY** for the form and student listed above
and **MUST BE RECEIVED** for processing.

DO NOT use staples or paperclips!



Please print and complete this form then
submit all pages including this coversheet via:

FAX		MAIL
(877) 447-9530 Outside of the United States? Please fax to (978) 244-8894	-OR-	**Magnus Health Does Not Accept Mailed Forms**

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
- HIVES OR WELTS
- ABDOMINAL PAIN,
- VOMITING, TINGLING IN MOUTH

☐ **Give Antihistamine** _____
_____

☐ **Give EpiPen®** ☐ **Give EpiPen Jr.**

☐ **Give Twinject 0.3 mg** ☐ **Give Twinject 0.15mg**

Watch for any one of the following symptoms of Anaphylaxis

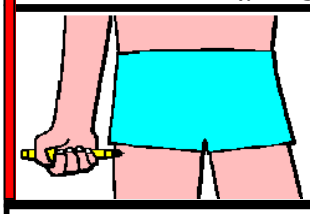
ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

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

SYMPTOMS
- DIFFICUL/NOISY BREATHING
- SWELLING OF TONGUE
- WHEEZING OR PERSISTENT COUGH
- DIFFICULTY SPEAKING OR HOARSE VOICE
- LOSS OF CONSCIOUSNESS
- PALE/FLOPPY (young children)

EpiPen® or Twinject administered immediately. Repeat every _____ minutes until the ambulance arrives.

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