Woodville Independent School District Health Services
Anaphylaxis Action Plan

Name_____ D.O.B._____ Teacher:_____

ALLERGY TO: _____

Asthmatic *Yes No *Higher risk for severe reaction

♦ STEP 1: TREATMENT ♦

Symptoms:	**Give Checked Medication:**
•If exposed to allergen, but no symptoms:	☐ Epinephrine ☐ Antihistamine
•Mouth Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
•Skin Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
•Gut Nausea, Abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
•Throat* Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
•Lung* Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
•Heart* weak pulse, low blood pressure, fainting, pale, blue	☐ Epinephrine ☐ Antihistamine
•Other* _____	☐ Epinephrine ☐ Antihistamine
•If reaction is progressing (several of the above areas affected) give:	☐ Epinephrine ☐ Antihistamine

The severity of symptoms can change quickly. ***Potentially life-threatening***

Dosage

Epinephrine: inject intramuscularly (circle one) Epipen Epipen Jr. Twinject .3mg Twinject .15mg
(See reverse side for instructions)

Antihistamine: give_____
Medication/dose/route

Other: give_____
Medication/dose/route

♦ STEP 2: EMERGENCY CALLS ♦

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr._____ at_____
3. Emergency Contacts:

Name/Relationship	Phone Numbers	
A._____	1) _____	2) _____
B._____	1) _____	2) _____
C._____	1) _____	2) _____

EVEN IF THE PARENT/GUARDIAN CANNOT BE REACHED,
DO NOT HESITATE TO MEDICATE OR TAKE THE CHILD TO A MEDICAL FACILITY!

Parent/Guardian Signature_____ **Date**_____

Physician's Signature_____ **Date**_____

Woodville Independent School District
Health Services
Diet Order Form

Student Name:	**School:**
DOB:	**Grade:**
Parent Name:	**Phone Number:**
Address:	**Cell Number:**

To be completed by a recognized medical authority such as licensed physician, physician's assistant or nurse practitioner. Diet modifications for a disability, medical condition, and allergy or food intolerance will only be made when omitted foods and appropriate substitutions are specified by a medical authority. If diet modifications are implemented by the school, they will continue for the school year or until a medical authority specifies that they should be changed or stopped. Parents /guardians are responsible for getting annually updated instructions for diet modifications from a medical authority each school year.

Diagnosis: _____

Diet Order: _____

Does this child have a "disability/handicap" affecting the diet? ____YES ____NO

Foods to be Omitted	Allowable Substitutions

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

_____ _____ _____

Physician's Signature | Office Number | Date