Ohio Department of Health

Anaphylaxis Emergency Action Plan

Order for Administration Epinephrine Autoinjector in Individuals WITHOUT a Specific Order

SYMPTOMS

For **Any** of the Following **SYMPTOMS**
(Stay with individual. Never leave alone.)
One or more of the following:

LUNG: Short of breath, wheezing, repetitive coughing

HEART: Pale, blue, faint, weak pulse, dizzy, confused

THROAT: Tight, hoarse, trouble breathing and/or swallowing/speaking

MOUTH: Significant swelling of the tongue and/or lips

SKIN: Many hives over body, widespread redness

GUT: Repetitive vomiting, severe diarrhea

NEURO: Feeling something bad is about to happen, anxiety, fear

ACTION STEPS

1. **INJECT EPINEPHRINE AUTOINJECTOR IMMEDIATELY! (See medication/dosage below)**
2. Call EMS (911)
3. Begin monitoring (see box below)
4. Send used autoinjector(s) to emergency department with individual or discard appropriately

MONITORING

Monitoring after 911 is called –Airway, Breathing, and Cardiac.
Stay with individual; alert healthcare professional, principal and parent.
Note:

- ☑ Record time epinephrine autoinjector used and inform rescue squad upon arrival.
- ☑ Continue to keep on back with legs elevated legs above the heart. If difficulty breathing or vomiting present, let individual sit up or lie on side.
- ☑ Provide First Aid/CPR as necessary; AED if necessary and available.

MEDICATION/DOSAGE

Medication/Dosage: Select appropriate epinephrine autoinjector dose, based on weight. If unable to assess weight, use larger dose. Review manufacturer's instructions for specific use of epinephrine autoinjector.

Dosage: ☐ 0.15mg Epinephrine autoinjector IM, if less than 66 pounds
☐ 0.30mg Epinephrine autoinjector IM, if 66 pounds or more
☐ A second epinephrine autoinjector dose can be given 5 or more minutes after the first if symptoms persist or recur.

Additional comments: _____

AUTHORIZED SIGNATURES

Licensed Healthcare Professional Authorized to Prescribe

Name/Title (Printed): _____ Practice Name: _____

Contact Phone Number: _____ Practice Address: _____

Signature: _____ Authorization Dates: Start _____Stop_____

School Use only:
School Administrator Authorization
Note: Administrator responsible for maintaining list of trained, designated personnel for epinephrine autoinjector

Name/Title (Printed): _____ School Building: _____

Signature: _____ Date: _____

This sample resource is located at the ODH School Nursing website,
http://www.odh.ohio.gov/odhprograms/chss/schnurs/schnurs1.aspx, click on "Forms"