TOWN OF ASHLAND, MASSACHUSETTS
RECREATION DEPARTMENT
162 West Union Street, 01721-1191
(508) 881-0140 x2
(508) 532 - 8092 (fax)

Anaphylaxis Emergency Action Plan

Child's Name: _____ M/F D.O.B. _____

Allergy To: _____

Asthma ☐ Yes (high risk for severe reaction) ☐ No

I, _____, authorize the staff of the Ashland Recreation Dept. to administer the following medications to my child _____ as prescribed by _____

	Medication	Dose		Medication	Dose
1			3		
2			4		

Permission to self administer if the Staff Member in charge determines it is safe and appropriate: Yes ___ No ___

Other health concerns besides anaphylaxis: _____

Concurrent medications, if any: _____

SYMPTOMS OF ANAPHYLAXIS INCLUDE:

MOUTH	itching, swelling of lips and/or tongue
THROAT*	itching, tightness. closure, hoarseness
SKIN	hives, itchy rash, redness, and/or swelling
GUT	nausea, vomiting, diarrhea and/or cramps
LUNG*	shortness of breath, coughing or wheezing
HEART*	weak pulse, dizziness and/or passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.
* Some symptoms can be LIFE-THREATENING! Act Fast!

WHAT TO DO:

1. INJECT EPINEPHRINE IN THIGH USING (check one) ☐ EpiPen Jr (0.15mg) ☐ EpiPen (0.3mg) ☐ Twinject (0.15mg) ☐ Twinject (0.3mg) ☐ Auvi-Q (0.15mg) ☐ Auvi-Q (0.3mg)

Other medication/dose/route: _____

*IMPORTANT: Asthma Puffers and/or Antihistamines can't be depended on in ANAPHYLAXIS!

2. **CALL 911** or RESCUE SQUAD (Before calling emergency contacts)!

3. Emergency Contacts

EC 1 _____ home_____ work_____ cell_____
EC 2 _____ home_____ work_____ cell_____
EC 3 _____ home_____ work_____ cell_____

DO NOT HESITATE TO GIVE EPINEPHRINE!

Comments: _____

_____

_____

_____ _____
Parent/Guardian Signature Date