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"