

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

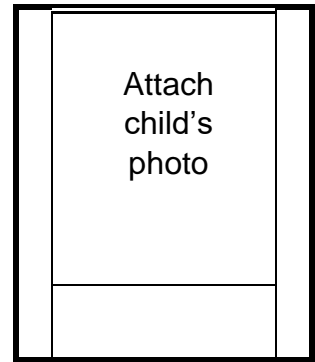


Child's name: _____ Date of plan: _____

Date of birth: ____/____/____ Age _____ Weight: _____ kg

Child has allergy to _____

- Child has asthma. Yes No (If yes, higher chance severe reaction)
 Child has had anaphylaxis. Yes No
 Child may carry medicine. Yes No
 Child may give him/herself medicine. Yes No (If child refuses/is unable to self-treat, an adult must give medicine)



IMPORTANT REMINDER

Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

<p>For Severe Allergy and Anaphylaxis What to look for</p> <p>If child has ANY of these severe symptoms after eating the food or having a sting, give epinephrine.</p> <ul style="list-style-type: none"> • Shortness of breath, wheezing, or coughing • Skin color is pale or has a bluish color • Weak pulse • Fainting or dizziness • Tight or hoarse throat • Trouble breathing or swallowing • Swelling of lips or tongue that bother breathing • Vomiting or diarrhea (if severe or combined with other symptoms) • Many hives or redness over body • Feeling of "doom," confusion, altered consciousness, or agitation <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><input type="checkbox"/> SPECIAL SITUATION: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, give epinephrine.</p> </div>	<p style="text-align: center;">➔</p> <p>Give epinephrine! What to do</p> <ol style="list-style-type: none"> 1. Inject epinephrine right away! Note time when epinephrine was given. 2. Call 911. <ul style="list-style-type: none"> • Ask for ambulance with epinephrine. • Tell rescue squad when epinephrine was given. 3. Stay with child and: <ul style="list-style-type: none"> • Call parents and child's doctor. • Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes. • Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side. 4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine. <ul style="list-style-type: none"> • Antihistamine • Inhaler/bronchodilator
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<p>For Mild Allergic Reaction What to look for</p> <p>If child has had any mild symptoms, monitor child.</p> <p>Symptoms may include:</p> <ul style="list-style-type: none"> • Itchy nose, sneezing, itchy mouth • A few hives • Mild stomach nausea or discomfort 	<p style="text-align: center;">➔</p> <p>Monitor child What to do</p> <p>Stay with child and:</p> <ul style="list-style-type: none"> • Watch child closely. • Give antihistamine (if prescribed). • Call parents and child's doctor. • If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")
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Medicines/Doses

Epinephrine, intramuscular (list type): _____ Dose: 0.10 mg (7.5 kg to less than 13 kg)*
 0.15 mg (13 kg to less than 25 kg)
 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): _____ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): _____

Parent/Guardian Authorization Signature _____ Date _____ Physician/HCP Authorization Signature _____ Date _____

I give permission for the release and exchange of information between the school nurse and my child's physician concerning my child's health and treatment.

I understand that neither the school district nor any of its employees shall be held liable for any injury resulting from self-medication, or lack thereof, and I agree to indemnify and hold harmless the school district and its agents against any related claims.

Parent/Guardian Signature: _____ Date: _____

Student verbalized and demonstrated appropriate use to school nurse:

School Nurse Signature: _____

Student Signature: _____

Emergency Contact:

First Contact:

Name: _____ Phone: _____

Relationship: _____

Emergency Contact:

Second Contact:

Name: _____ Phone: _____

Relationship: _____

District guidelines permit a responsible, trained student to carry on his/her person medication/supplies for asthma, severe allergic (anaphylactic) reaction, and/or diabetes. Permission is also granted for self-administration of this medication for immediate use during a health-threatening situation with written order of their private physician, and written approval of a parent/guardian and school nurse.

Medication must be carried in a safe manner, such as a backpack or purse. Student will be responsible to carry their medication with them to all off-campus school related functions independent of the school nurse's office.

SELF- MANAGEMENT PRIVILEGES MAY BE REVOKED IF THE CORRECT PROCEDURES ARE NOT FOLLOWED.

Licensed Prescriber orders are effective for one school year and must be renewed annually or when there is a change in prescription.