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

Attach child's photo

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-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- 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

☐ **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**.

Give epinephrine! What to do

1. Give epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - 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.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child What to do

Stay with child and:

- 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.")

Medicines/Doses

Epinephrine (list type): _____ Intramuscular: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)
(*Use 0.15 mg, if 0.10 mg is not available)

Intranasal: ☐ 2 mg (30 kg or more)

**If more than one epinephrine is selected, then either one can be used

Antihistamine, by mouth (type and dose): _____

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

_____ _____ _____ _____

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

See Back Page

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Child's name: _____ **Date of plan:** _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: _____

Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contacts

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Student Name_____

Parent/Guardian AUTHORIZATIONS: Please mark either number 1. Or Number 2. Please do not mark both.

_____ **1**. I want this allergy plan implemented for my child; I **DO WANT** my child to carry & self-administered an epinephrine auto injector. I agree to release the school district & school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of an auto injector.

_____ **2.** I want this plan implemented for my child and I **DO NOT** want my child to self-administer epinephrine.

_____**3**. It is recommended that back up medication be stored with the school in case student forgets or loses auto injector &/or antihistamine. The school district is not responsible or liable if backup medication is not provided to the school and student is without working medication when medication is needed.

Parent/Guardian Signature:_____

Phone:_____ Date:_____

Student Agreement: Please mark 1.-4.

_____ **1.** I have been trained in the use of my auto injector& allergy medication & understand the signs & symptoms for which they are given

_____ **2**. I agree to carry my auto injector with me at all times:

_____**3**. I will notify a responsible adult (teacher, nurse, coach, office staff, etc.) **IMMEDIATELY** when I use my auto injector (epinephrine).

_____**4**. I will not share my medication with other students or leave my auto injector unattended and I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature:_____ Date:_____

Medication Administration Form

Epinephrine (Epi Pen)

PERRY COUNTY SCHOOL DISTRICT

PARENT AUTHORIZATION AND INDEMNITY AGREEMENT/MEDICATIONS RELEASE:

The undersigned parent/s or guardian/s of _____, a minor child, has requested personnel(s) of the Perry County School District to administer the prescribed medicine by a physician to this student. This request has been made for my/our convenience as a substitute for parental administration of this medicine. It is understood that the school administration will designate a school personnel (s) [who will not need a medical or nursing licenses],&/or school nurse to assist/observe my child taking the prescribed medicine ordered by a physician. I/We forever release, discharge and covenant to hold harmless the school district, its personnel and board of trustees from any claims, demands, damages, expenses, loss of services and cause of action belonging to the minor child or to the undersigned arising out of or on account of any injury, sickness, disability, loss or damages of any kind resulting from the administration of the prescription medicine. The unsigned agree to repay the school district, its personnel or trustees any sum of money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any action or on account of any injury to the minor child as a result of the administration of medicine. I have read the foregoing release and indemnity agreement and fully understand it. Executed this the _____day of _____, 20_____.

_____ _____

Signature of Parent/Guardian **Witness**

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name:_____ DOB/Age_____ Grade _____

School_____ Teacher_____ School year_____

HT_____WT_____ Allergies/Reactions_____

I request my child name and identified above to receive:

_____ Medication as prescribed by our physician on the form below or as listed on the container issued by the pharmacy.

_____Non-prescription/over-the-counter medication provided by me along with Dr.'s order

I understand and consent to the release of the information to all school personnel(s) and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I consent to communication between the prescribing physician, the Pharmacist, and the school nurse, necessary for the management and administration of medications pertaining to my child's medical condition. I authorize the school administration to designate a school personnel(s)(who will not need a medical or nursing licenses),or school nurse to assist/observe my child taking the prescribed medication ordered by a physician that is listed below. I understand that Perry County school district is rendering a service and does not assume any responsibility for this matter. **Name of medication**:_____

Signature of Parent/guardian_____Date:_____phone#_____

Emergency Contacts: Name:_____ Phone#_____

PRESCRIBER AUTHORIZATION (TO BE FILLED OUT BY THE DR.)

StudentName:_____DOB_____Allergies:_____

Name of Medication_____ Strength [**# milligrams(MG**)]_____

Dosage **[# of pills to take/ liquid to take**]_____ Route:_____

Frequency (**Time to be given at school)_____**

Date to begin medication:_____ Date to stop med._____

Reason for taking the medication:_____

Potential side ffects/adversereactions:_____

Any special instructions or Recommendations: _____

Physician Signature:_____ Physician Name: _____

Name of Clinic:_____ Date:_____ Phone #_____

If Benadryl is needed, see *back* page (Page 4)

Medication Administration Form

Benadryl

PERRY COUNTY SCHOOL DISTRICT

PARENT AUTHORIZATION AND INDEMNITY AGREEMENT/MEDICATIONS RELEASE:

The undersigned parent/s or guardian/s of _____, a minor child, has requested personnel(s) of the Perry County School District to administer the prescribed medicine by a physician to this student. This request has been made for my/our convenience as a substitute for parental administration of this medicine. It is understood that the school administration will designate a school personnel(s) (who will not need a medical or nursing licenses),&/or school nurse to assist /observe my child taking the prescribed medicine ordered by a physician. I/We forever release, discharge and covenant to hold harmless the school district, its personnel and board of trustees from any claims, demands, damages, expenses, loss of services and cause of action belonging to the minor child or to the undersigned arising out of or on account of any injury, sickness, disability, loss or damages of any kind resulting from the administration of the prescription medicine. The unsigned agree to repay the school district, its personnel or trustees any sum of money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any action or on account of any injury to the minor child as a result of the administration of medicine. I have read the foregoing release and indemnity agreement and fully understand it. Executed this the _____day of _____, 20_____.

_____ _____

Signature of Parent/Guardian **Witness**

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name:_____ DOB/Age_____ Grade _____

School_____ Teacher_____ School year_____

HT_____WT_____ Allergies/Reactions_____

I request my child name and identified above to receive:

____ Medication as prescribed by our physician on the form below or as listed on the container issued by the pharmacy.

____Non-prescription/over-the-counter medication provided by me along with Dr.'s order

I understand and consent to the release of the information to all school personnel(s) and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I consent to communication between the prescribing physician, the Pharmacist, and the school nurse, necessary for the management and administration of medications pertaining to my child's medical condition. I authorize the school administration to designate a school personnel(s)(who will not need a medical or nursing licenses),or school nurse to assist/ observe my child taking the prescribed medication ordered by a physician that is listed below. I understand that Perry County school district is rendering a service and does not assume any responsibility for this matter.

Name of medication_____ Date:_____

Signature of Parent/guardian_____**phone#**_____

Emergency Contacts: Name:_____ **Phone#**_____

PRESCRIBER AUTHORIZATION (TO BE FILLED OUT BY THE DR.)

StudentName:_____DOB_____Allergies:_____

Name of Medication_____ Strength [**# milligrams(MG**)]_____

Dosage **[# of pills to take/ liquid to take**]_____ Route:_____

Frequency (**Time to be given at school)**_____

Date to begin medication:_____ Date to stop med._____

Reason for taking the medication:_____

Potential side ffects/adversereactions:_____

Any special instructions or Recommendations: _____

Physician Signature:_____ **Physician Name:** _____

Name of Clinic:_____ **Date:**_____ **Phone #**_____

See page 5

LETTER FOR THE CAFETERIA STAFF

This form needs to be filled out by the DOCTOR office only:

Student Name:_____

Name of School:_____

GRADE: _____ DATE:_____

To whom it may concern: (Cafeteria Staff)

He/She is allergic to the following foods :

_____

_____

_____

PHYSICIAN SIGNUTARE:_____

PHYSICIAN NAME (PRINT)_____

NAME OF THE CLINIC: _____

PHONE NUMBER:_____

Parent to fill out the back page (see page 6)

Perry County School District
Individualized Health care Plan
Allergies

PARENT TO FILL OUT THIS PAGE

StudentName:_____DOB/Grade:_____School Year:_____

Homeroom Teacher:_____ _Diagnoses: **ALLERGIES**_____Student Wt: _____

Nursing Diagnosis (ND)	Nursing Intervention	Nursing goals/outcomes
1. Risk for allergy response (Anaphylaxis reaction) related to potential exposure to allergen.	*Monitor for exposure/reaction to known allergens (Anaphylaxis reaction) **& treat immediately as ordered by MD as appropriate.** Have allergy action plan on file. *If reaction occurs/treatment given such as: 1.Follow action plan & MD order 2. **stay with student, call 911, and parent.** Tell 911 &/or rescue squad if epi pen was given. 3. Note time when epi pen was given.	*Student will not experience a reaction (Anaphylaxis reaction) from exposure to Allergen. *Student will receive appropriate treatment if exposed to/ reacting to an allergen *Student will maintain health and well-being necessary for learning and Action Plan will need to be on file.

Please list all items &/or food student is known to have allergic reactions:_____

Please describe the reactions:_____

_____

I_____(parent/guardian) give permission to the school administration to designate a school personnel(s)(who will not need a medical or nursing license),or school nurse to assist/ observe my child taking the prescribed medication which is (name of medication) _____ and to perform and carry out the care as outlined in (student's name)_____ Individualized Healthcare Plan. I also consent to the release of the information contained in this Individualized Healthcare Plan to all school personnel(s) and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I consent to communication between the prescribing physician, the school nurse, & the designated school personnel(s) (which is assigned by the school administration) necessary for the management and administration of medications pertaining to my child's medical condition addressed on this Individualized Healthcare Plan.
Parent/guardian Signature:_____Date_____Phone#_____

Emergency Contacts: Emergency Contacts Persons

1.:_____Phone#_____

2. _____Phone#_____