

ANAPHYLAXIS EMERGENCY CARE PLAN

Date of Plan: / /

This plan is valid for the current school year: 20 - 20

STUDENT INFORMATION

Name _____ DOB / / Grade School _____

ALLERGY INFORMATION

Known Allergen(s): _____

Asthma* Yes No * high risk for severe reaction

Signs and Symptoms of Anaphylaxis:



MOUTH

itching, swelling of lips and/or tongue



SKIN

rash, itching, hives, redness, swelling



LUNG

shortness of breath, cough, wheeze



THROAT

itching, tightness/closure, hoarseness



GUT

nausea, vomiting, abdominal cramps



HEART

confused, weak pulse, dizziness, passing out

The symptoms of a reaction are not always consistent and could include any of the above.

The severity of symptoms can change quickly.

All of the symptoms can potentially progress to a life-threatening situation!

ANAPHYLAXIS EMERGENCY PROTOCOL

1. **Inject epinephrine (as ordered below) IMMEDIATELY!**
2. **CALL 911 (Request an ambulance and specify that child is having an anaphylactic reaction)**
3. **Give another epinephrine dose within 15 minutes if symptoms return or worsen and emergency services have not arrived.**
4. **Alert contact(s):**

Parent/Guardian _____ Phone _____ Phone (C) _____

Parent/Guardian _____ Phone _____ Phone (C) _____

Emergency Contact _____ Phone _____ Phone (C) _____

Preferred hospital _____

PHYSICIAN'S AUTHORIZATION FOR MEDICATION ADMINISTRATION

EPINEPHRINE DEVICE	DOSAGE	TIME	COMMON SIDE EFFECTS/SPECIAL INSTRUCTIONS

Self-Carry If yes, I understand this student will carry the above listed medication at school. I also understand this student will be entirely responsible for the use of this medication and use of this medication will not be monitored by school personnel.
 Yes No

OTHER PERTINENT MEDICATION	DOSAGE	TIME	COMMON SIDE EFFECTS/SPECIAL INSTRUCTIONS

Physician's signature **X** _____ Date / /

Physician (Printed Name) _____ Phone _____

Clinic _____ Fax _____

SPECIAL CONSIDERATIONS & PRECAUTIONS (regarding school activities, sports, field trips, etc.)

AUTHORIZATION FOR STAFF ADMINISTRATION OF MEDICATION

I give permission for the school nurse to consult with my child's physician concerning any questions that arise with regard to the listed medication or my child's medical condition. I understand that trained school personnel (e.g. classroom teacher, paraprofessionals, health office staff, office staff) will follow the Anaphylaxis Emergency Care Plan as completed by my child's physician, Licensed School Nurse, & myself.

Parent/Guardian signature _____ Date / /

Licensed School Nurse signature _____ Date / /

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Not Applicable

I hereby authorize my child to self-administer the above named medication during school as prescribed by the physician.

I have read the student agreement.

I understand my child will carry this medication at school and use will not be monitored by school personnel.

I understand that trained school personnel (e.g. classroom teacher, paraprofessionals, health office staff, office staff) will follow the Anaphylaxis Emergency Care Plan as completed by my child's physician, Licensed School Nurse, and myself should my child be unable to self-administer his/her medication.

Parent/Guardian signature _____

Date / /

STUDENT AGREEMENT

I AGREE TO:

Follow my prescribing physician's medication orders.

Use correct medication administration technique.

Not allow anyone else to use my medication.

Keep a supply of my medication with me in school and on field trips.

Notify the school nurse or health office personnel if my epinephrine is administered and 911 will be called.

Notify the school nurse or health office personnel if I have any exposure to allergy-causing food or substances or exhibit any symptoms of an allergic reaction.

Student signature _____

Date / /

The student has demonstrated knowledge about proper use of his/her medication (epinephrine administration device)

LSN signature _____

Date / /