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ANAPHYLAXIS EMERGENCY CARE PLAN

Date of Plan: / / This plan is valid for the current school year: 20 - 20

STUDENT INFORMATION

Name DOB / / Grade Teacher

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 ☐ Yes ☐ No — 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.

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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SELF-ADMINISTRATION OF MEDICATION

☐ 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 of 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 ___/___/___