

## **ANAPHYLAXIS EMERGENCY CARE PLAN**

	of Plan: / / This plan is valid for the current school year: 20 - 20						
STUDENT INFO	RMATION						
Name		DOB	1 1	Grade	Teacher		
ALLERGY INFO	RMATION						
Known Aller	gen(s):						
Asthma* Ye	es No	* high risk for severe	reaction				
Signs and S	Symptoms of	Anaphylaxis:					
	MOUTH		SKIN		LUN	NG	
	itching, swelling of and/or tongue	flips	rash, itching, hive redness, swelling			ness of breath	, cough,
	THROAT		GUT	6	THE/	ART	
(1)	itching, tightness/o	closure,	nausea, vomiting abdominal cramp		confu	used, weak pul ness, passing o	
•		are not always con n change quickly.	sistent and cou	ld include any	of the above	e.	
•	• •	entially progress to	a life-threatenin	na situation!			
·	•	NCY PROTOCO					
		rdered below) <u>IMN</u>					
	-	-		l io boving on	ononhyloo	tia raaatian	`
	• •	mbulance and sp	_	•			)
3 GIVE ANOT	iner ebinebnrir	e dose within 15	minutes it sym	iptoms return	or worsen	and	
	•		•	•			
emergency s	services have r		•				
emergency s 4. Alert cont	services have r	not arrived.					
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## **ANAPHYLAXIS EMERGENCY CARE PLAN**

## **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-c exhibit any symptoms of an allergic reaction.	ausing foo	d or subs	tances or				
Student signature	Date	/	/				
The student has demonstrated knowledge about proper use of his/her medication (epine	phrine adm	ninistratio	n device)				

Date

LSN signature