Allergy and Anaphylaxis Emergency Plan

Attach Child's Photo

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 self carry medication ▢ Yes ▢ No
Child may give him/herself medicine ▢ Yes ▢ No (If child refuses/is unable to self-treat, an adult must give medication.)

IMPORTANT REMINDER

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

For Severe Allergy and Anaphylaxis
What to look for

If a 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 and 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 the 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 eses foods, give epinephrine

Give Epinephrine!
What to do

1. Inject epinephrine right away! Note the time when epinephrine was given.
2. Call 911
   a. Report anaphylactic reaction
   b. Tell the rescue quad when epinephrine was given.
3. Stay with child and :
   a. Call parents
   b. Give a second dose of epinephrine, if symptoms get worse, continue, or do not bet better in 5 minutes.
   c. Keep the child lying on the back. If the child vomit or has trouble breathing, keep the child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine
   a. Antihistamine
   b. Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

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

- Itchy nose, sneezing, itchy mouth
- Hives
- Mild Stomach nausea or discomfort

Monitor child
What to do

Stay with child and :

- Watch the child closely.
- Give antihistamine (if Prescribed)
- Call Parents
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine, (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type):_____Dose: □ 0.15 mg □0.30 mg (wt more than 25 kg)

Antihistamine, by moujth (type and dose):_____

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

Special Diet Request -Food Allergy

Students with food intolerance/non-life threatening allergies will have an alert placed on their student nutrition account to prevent consumption.

We encourage parents and students to view school menus on the district's website for more allergy information.

Select the appropriate box based on the student's allergy reaction.

☐ Life-Threatening Allergy - Anaphylactic

☐ Non-Life Threatening Allergy/Food Intolerance

Milk/Dairy Allergy: ☐ Avoid fluid milk only ☐ Avoid all dairy products) ☐ Avoid dairy in baked goods

Eggs: ☐ Whole Eggs ☐ Egg as an ingredient (eggs used to make a recipe, Pancakes)

Nuts: ☐ Peanuts ☐ Tree nut (Walnuts, pecans, almonds, hazelnuts..etc.)

Soy: ☐ Avoid Soy milk only ☐ Avoid all soy containing products ☐ Wheat ☐ Fish ☐ Shellfish

Food Substitutes:_____

Name of Medical Authority:_____

Prescribing Medical Authority Signature:_____ Date:_____

Contact Phone Number:_____Fax #:_____

Student /Parent/Guardian Agreement (check the boxes to indicate agreement):

☐ I would like for my classmates and /or their parents to be aware of my food allergy.

Before/after school programs/extracurricular activities: ☐ Athletics ☐ Band/ Orchestra ☐ Drill Team ☐Cheer ☐Choir

☐ Other (list):_____

How does your child get home? ☐ Parent/Daycare pick-up ☐ Walk ☐ Bus #_____

Elementary Students: I would like for my child to sit in a Peanut/nut/Allergen-Aware Zone in the cafeteria. ☐ Yes ☐ No

Self Carry

☐ I have been trained in the use of my EpiPen (or other auto-injector epinephrine) and prescribed allergy medication and understand the signs and symptoms for which they are to be given.

☐ I know it is my responsibility to keep my medication with me so that it is easily accessible in case of an emergency during school hours, extracurricular activities and field trips.

☐ I will notify a responsible adult (teacher, nurse, coach, etc.) **IMMEDIATELY** when EpiPen is used.

☐ I will not share my medication, leave my EpiPen unattended, or use my medication for any other use that for which it is prescribed.

☐ I will inform the school nurse and my parents if my mediation is lost, stolen, or has expired.

It is recommended that backup medication is stored with the school/school nurse in case a student forgets or loses their EpiPen. The school district is not responsible or liable if backup medication is not provided to the school/school nurse and the student is without working medication when medication is needed.

Your signature gives permission for the nurse to implement this action plan and to contact and receive additional information from your healthcare provider regarding the allergic condition(s)and the prescribed mediation. Anaphylaxis Action Plan will be shared with school personnel with legitimate educational interests.

Parent/Guardian Signature: _____ Phone:_____Date:_____

Students Signature (if self-administering):_____Backup medication stored at school? ☐ Yes ☐ No

Approved by Nurse/Principal Signature: _____Date:_____