

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

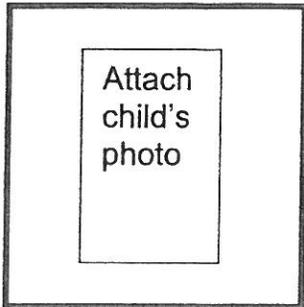


Child's name: _____ Date of plan: _____

Date of birth: ___/___/___ Age ___ Weight: _____ kg

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

<p>For Severe Allergy and Anaphylaxis What to look for</p> <p>If child has ANY of these severe symptoms after eating the food or having a sting, give epinephrine.</p> <ul style="list-style-type: none"> • 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 <div style="border: 1px solid black; padding: 5px;"> <p><input type="checkbox"/> 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.</p> </div>	<p style="text-align: center;"></p> <p>Give epinephrine! What to do</p> <ol style="list-style-type: none"> 1. Inject epinephrine right away! Note time when epinephrine was given. 2. Call 911. <ul style="list-style-type: none"> • Ask for ambulance with epinephrine. • Tell rescue squad when epinephrine was given. 3. Stay with child and: <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • Antihistamine • Inhaler/bronchodilator
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<p>For Mild Allergic Reaction What to look for</p> <p>If child has had any mild symptoms, monitor child.</p> <p>Symptoms may include:</p> <ul style="list-style-type: none"> • Itchy nose, sneezing, itchy mouth • A few hives • Mild stomach nausea or discomfort 	<p style="text-align: center;"></p> <p>Monitor child What to do</p> <p>Stay with child and:</p> <ul style="list-style-type: none"> • Watch child closely. • Give antihistamine (if prescribed). • Call parents and child's doctor. • If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")
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Medicines/Doses

Epinephrine, intramuscular (list type): _____ Dose: 0.15 mg 0.30 mg (weight more than 25 kg)
 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 _____

Individualized Health Care Plan/Emergency Action Plan

Student Name: _____

- **EMERGENCY CONTACTS: Name/Contact Number**

Mother: _____

Father: _____

Other: _____

- **It is the parent's responsibility to notify the bus company of any life-threatening allergy that your child has.**

- **Please check if any of the following are needed:**

_____ My child REQUIRES a NUT FREE table for meals

_____ My child DOES NOT require a NUT FREE table for meals

In the absence of a School Nurse Teacher, Epinephrine will be administered immediately by a trained staff person in the event that there is ANY suspicion of exposure to the allergen.

Signing this form gives the School Nurse Teacher permission to share this information with applicable staff for health and safety of the above named student.

Parent Signature: _____ Date: _____

School Nurse Teacher: _____ Date: _____