Life-Threatening Allergy Management Plan Rev.8/16

To be completed by MD: Valid for Current School Year _____

Name: _____ DOB: _____ Weight_____

Allergy to: _____

Asthma: □ Yes (high risk for severe reaction) □ No □ See Asthma Action Plan

Extremely Reactive to: _____
If known exposure, give epinephrine immediately and call 911.

Action for Mild Reaction:

Systems:	Symptoms:
Mouth:	itchy mouth
Skin:	minor itching "and/or" a few hives
Gut:	mild nausea/discomfort

Liquid

□ diphenhydramine (12.5mg/5ml) p.o. (can be repeated q 4-6 hours)
□ cetirizine (5mg/5ml) p.o. (do not repeat)
Dose: _____

Stay with student. Alert parent. If symptoms worsen then follow steps for major reaction.

Action for a Major Reaction: (two systems or single severe symptom)

Systems:	Symptoms:
MOUTH	swelling of the lips, tongue, or mouth
THROAT	tight throat, hoarseness, drooling, trouble swallowing
LUNG	shortness of breath, repetitive cough and/or wheezing
HEART	thready pulse, faint, confused, dizzy, pale, blue
SKIN	multiple hives, swelling about the face and neck
GUT	abdominal cramps, vomiting

1. Inject Epinephrine immediately intramuscularly
□ Epinephrine 0.3 mg_____ □ Epinephrine 0.15mg _____

2. Call RESCUE SQUAD 911 ASK FOR ADVANCED LIFE SUPPORT
- **Students should not suddenly sit up, stand or be placed in the upright position. This increases risk for sudden death.**

3. Note time epinephrine was given and repeat dose after 5 minutes if no improvement or worsening symptoms.
- **Antihistamines and inhalers are not first line therapy in a severe reaction.**

4. Transport via EMS to the emergency department.

Emergency Contacts:
Parent/Guardian _____ Phone: _____
Other emergency contact _____ Phone: _____

_____ _____ _____ _____
Parents Signature **DATE** **DOCTOR'S SIGNATURE** **DATE:**

_____ _____ **Print MD Name:** _____
Nurses Signature **DATE** **Contact number:** _____

Life-Threatening Allergy Management Plan (LAMP)

Permission to Carry and/or Self-Administer Epinephrine (if appropriate)

Name: _____ DOB: _____

I, as the Healthcare Provider, certify that this child has a medical history of severe allergic reactions has been trained in the use of the prescribed medication(s) and is judged to be capable of carrying and self-administering this medication(s). The nurse or the appropriate school staff should be notified anytime the medication/injector is used. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice.

☐ Self-Carry
☐ Self-Administer

_____ _____ _____
Healthcare Provider Signature Print Healthcare Provider name Date

---

In accordance with the Code of Virginia Section 22.1-274, I agree to the following:

I will not hold the school board or any of its employees liable for any negative outcome resulting from the self-administration of said emergency medication by the student.

I understand that the school, after consultation with the parent(s) may impose reasonable limitations or restrictions upon a student's possession and/or self-administration of said emergency medication relative to the age and maturity of the student or other relevant consideration.

I understand that the school may withdraw permission to possess and self-administer the said emergency medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that the student is not safely and effectively self-administering the medication.

_____ _____
Parent/Guardian Signature Date

_____ _____
Student Signature Date

Revised 8/16