

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics



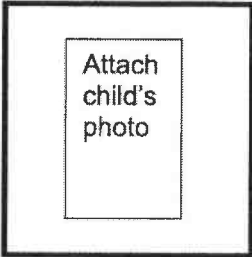
DEDICATED TO THE HEALTH OF ALL CHILDREN™

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.

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| <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 <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> | <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>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 _____

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Additional Instructions:

Contacts

Call 911 / Rescue squad: () _____ - _____

Doctor: _____ Phone: () _____ - _____

Parent/Guardian: _____ Phone: () _____ - _____

Parent/Guardian: _____ Phone: () _____ - _____

Other Emergency Contacts

Name/Relationship: _____ Phone: () _____ - _____

Name/Relationship: _____ Phone: () _____ - _____

COLLIER YOUTH SERVICES

TRAINING A DELEGATE

PERMISSION FOR EPINEPHRINE INJECTION DURING SCHOOL

Student's Name: _____ DOB: _____

I request the school's nurse or trained designee administer the Epinephrine that I have provided for the above-named student.

The names of school personnel, other than the school nurse, who are trained to administer Epinephrine are documented in the Epinephrine Training Manual.

Identify the specific food, drug or other substance to which the above-named student is allergic:

I request the school's nurse or trained designee provide epinephrine whenever there is evidence of hives, rashes, tingling, itching, respiratory distress or other sign of allergic reaction in the above-named student.

I will supply a prescription from this student's health-care provider for this medication. I understand these prescriptions and this permission form are valid for one calendar year unless otherwise specified.

I hold harmless Collier Youth Services and all of its employees.

Printed Name of Person Completing

Signature of Person Completing Form

Relationship to Student

Date

Name of Health-Care Provider