Children's Hospital of The King's Daughters, Inc.
601 Children's Lane, Norfolk, VA 23507-1910

Allergy/Immunology Department

Allergy and Anaphylaxis Emergency Plan
(Life-threatening Allergy Management Plan)

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

To be completed by provider: Valid for School Year _____

Name: _____ DOB: _____Weight_____

Allergy to: _____

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

Administer Epinephrine immediately (Can repeat after 5 minutes if no improvement):

❒ **Epinephrine 0.3 mg IM (≥ 25 kg)** ❒ **Epinephrine 0.15 mg IM (12 < 25kg)**

❒ **Epinephrine 0.1 mg IM (<12 kg)** ❒ **Epinephrine __mg intranasal (≥ 25 kg)**

If child at school or daycare

+

If home management is not approved

→ **Call 911 and transport now**

Action for Mild Reaction:

Systems:	Symptoms:
MOUTH	itchy mouth
SKIN	minor itching "and/or" a few hives
GUT	mild nausea

Liquid medication:

□ **cetirizine (5mg/5ml) p.o.**

Dose: _____

OR

□ **diphenhydramine (12.5mg/5ml) p.o. (can be repeated q 4-6 hours)**

Dose: _____

Stay with child. Alert parents. If symptoms worsen, then follow steps for major reaction.

Emergency Contacts:

Parent/Guardian_____ Phone: _____

_____ _____ _____ _____

PARENT'S SIGNATURE **DATE** **HEALTHCARE PROVIDER'S SIGNATURE** **DATE**

_____ _____ **Print Healthcare Provider's Name:**_____

NURSE'S 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