TN Department of Education

Allergy and Anaphylaxis Emergency Plan

Date of Plan: _____

Student's Name: _____ Date of Birth: _____ Age: ____ Weight: _____ pounds (____ kg)
Student's School System: _____ Student's School: _____
Student has allergy to _____
Student has asthma ☐ Yes (If yes, higher risk for severe reaction) ☐ No
Student has had anaphylaxis ☐ Yes ☐ No
Student has received instruction and has permission to self-carry epinephrine and use independently ☐ Yes ☐ No

IMPORTANT REMINDER: Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, use epinephrine.

For **ANY** of the following **SEVERE SYMPTOMS** **OR A COMBINATION** of symptoms from different body areas


Shortness of breath, wheezing, or coughing


Pale or bluish skin, weak pulse, fainting or dizziness


Tight or hoarse throat, trouble breathing or swallowing


Swelling of lips or tongue that bothers breathing


Many hives or redness over body


Feeling of "doom," confusion, altered consciousness or agitation


Repetitive vomiting or severe diarrhea

☐ **SPECIAL SITUATION:** If this box is checked, student 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.**

1. Inject epinephrine right away!
Note time when epinephrine was given.

2. Call 911.
- Ask for ambulance with epinephrine.
- Tell rescue squad when epinephrine was given.

3. Stay with Student and:
- Call parents and student's healthcare provider.
- If symptoms get worse or continue after 5 minutes, give a second dose of epinephrine.
- Keep student lying on back. If the student vomits or has trouble breathing, keep child lying on his or her side.

4. Give other medicine (if applicable) following epinephrine
- Antihistamine
- Inhaler/bronchodilator if wheezing

MILD SYMPTOMS


Itchy or runny nose, sneezing


Itchy mouth


Mild nausea or discomfort


A few hives, mild itchy skin

MONITOR STUDENT

- Stay with student and watch him or her closely.
- Give antihistamine (if listed below).
- Call parents.

If more than 1 symptom or severe allergy anaphylaxis symptoms develop, use epinephrine.

MEDICATION/DOSES

Epinephrine, intramuscular (list type):
_____
Epinephrine Dose: ☐ 0.1 mg ☐ 0.15 mg ☐ 0.3 mg

Antihistamine, by mouth (list type): _____
Antihistamine Dose: _____
Other (e.g., inhaler/bronchodilator if child has asthma):
_____

EMERGENCY CONTACTS

Healthcare Provider: _____
Phone: _____
Parent/Guardian: _____
Phone: _____
Other Emergency Contact Name/Relationship:
_____
Phone: _____

_____ _____
Parent/Guardian Authorization Signature Date

_____ _____
Physician/HCP Authorization Signature Date

PARENT/GUARDIAN TO COMPLETE THE SECTION BELOW

Student's Name: _____ Date of Birth: _____
Father's Name: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Mother's Name: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Emergency Contact if parent not available: _____
(Authorized to act on behalf of parents if we are unable to contact parent)

Home Phone: _____ Cell Phone: _____ Work Phone: _____
Physician Name: _____ Phone: _____ Fax: _____
Please describe any previous reaction(s) and date of reaction that your child has had to this food. Describe symptoms and treatment that was required for the reaction(s).

_____
_____
_____

My child _____ WILL _____ WILL NOT (check one) possess an epinephrine auto-injector (provided by parent) to self-administer on school property or at school events according to this healthcare plan. I release FSSD or its employees from liability as a result of my child's failure to carry or administer the medication according to the physician orders in this individualized healthcare plan.

Epinephrine auto-injector. (provided by parent) _____ WILL _____ WILL NOT be carried by child on Bus # _____.

- EPINEPHRINE AUTO-INJECTORS ARE TO BE PROVIDED BY THE PARENT/GUARDIAN TO BE KEPT AT SCHOOL AND AVAILABLE FOR THE STUDENT DURING SCHOOL AND ON FIELD TRIPS. IF STUDENT IS A BUS RIDER, AN ADDITIONAL AUTO-INJECTOR SHOULD BE PROVIDED FOR BUS TRANSPORTATION. IN THE EVENT THAT AN EPINEPHRINE AUTO-INJECTOR IS NOT AVAILABLE, 911 WILL BE CALLED.
- EXPIRED AUTO-INJECTORS MUST BE REPLACED. AN EXPIRED AUTO-INJECTOR CANNOT BE ADMINSTERED BY THE SCHOOL NURSE OR OTHER TRAINED ASSISTIVE PERSONNEL.
- MEDICATIONS MUST BE PICKED UP BY A PARENT/GUARDIAN AT THE END OF THE SCHOOL YEAR. MEDICATIONS NOT PICKED UP WILL BE DISPOSED OF ACCORDING TO STATE REGULATIONS.

SCHOOL NURSE TO COMPLETE THE SECTION BELOW

The following staff are trained to administer Epinephrine for this student:
_____ Location in building: _____
_____ Location in building: _____
_____ Location in building: _____
Location in building of child's Epinephrine: _____

On field trips, Epinephrine will be with: _____
I understand that health information regarding my child will be kept confidential, but shared with school personnel on a need to know basis in order to protect the health and safety of my child. I release the Franklin Special School District from any legal claim and assume full responsibility for any adverse reactions my child may suffer as a result of taking or failing to take the medication. I understand that my child may be administered medication/procedures on field trips or in the absence of a school nurse by unlicensed, trained personnel (such as a teacher/school employee). I understand that my child will be administered medications and emergency treatment as indicated by the physician orders on other side of this form. This treatment will be administered even if a parent/guardian cannot be reached. The physician completing the other side of this form has permission to provide this and other information regarding my child's health needs to the school nurse, principal or designated assistive personnel. The school nurse has my permission to speak with my child's physician regarding this plan and related health issues to promote the health and safety of my child. I understand and agree that my child may be assisted with medication administration/procedures on field trips or in the absence of a school nurse by unlicensed trained personnel (such as a teacher). I understand that if emergency medications have not been provided by the parent/guardian, 911 will be called. I agree this health plan meets the needs of my child.

_____	_____	_____
Parent/Guardian Name (Print)	**Parent/Guardian Signature**	**Date**
_____	_____	_____
Nurse Name (Print)	**Nurse Signature**	**Date**