

**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 _____

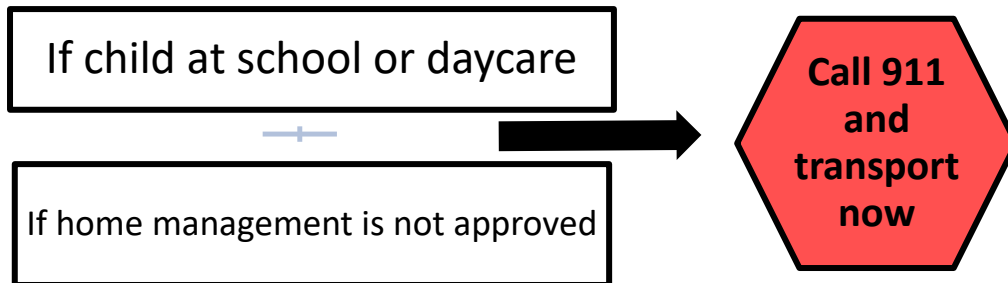
Allergy to: _____

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

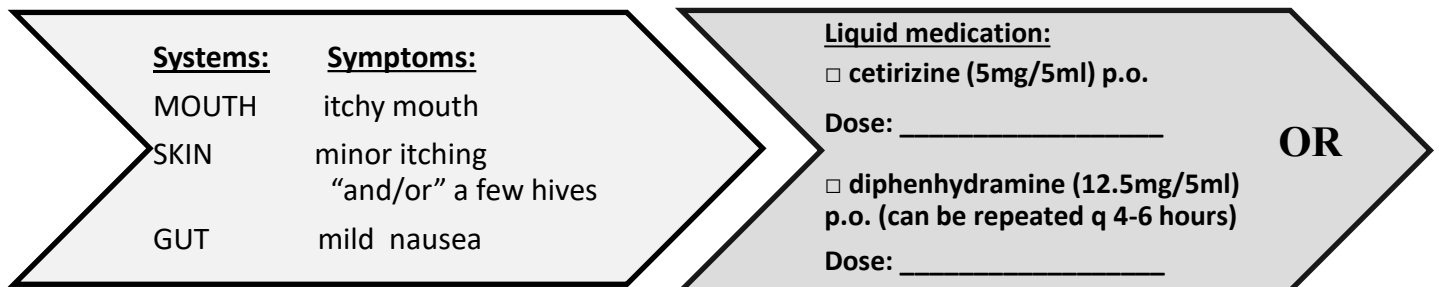
<u>Systems:</u>	<u>Symptoms:</u>
MOUTH	swelling of the lips, tongue, or mouth
THROAT	tight throat, hoarseness, drooling, trouble swallowing
LUNG	shortness of breath, repetitive cough and/or wheezing
HEART	thready pulse, faint, confused, dizzy, pale, blue
SKIN	multiple hives, swelling about the face and 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 ($12 < 25$ kg)
☐ Epinephrine 0.1 mg IM (<12 kg) ☐ Epinephrine ____mg intranasal (≥ 25 kg)



Action for Mild Reaction:



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

NURSE'S SIGNATURE

DATE

Print Healthcare Provider's Name: _____

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