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: ____

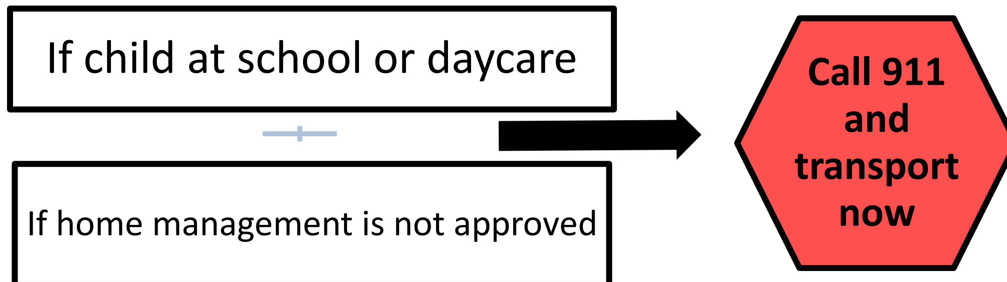
Action for a Major Reaction: (two systems or single severe symptom)

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 2mg intranasal (≥ 25 kg)**



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. (don't repeat)**

Dose: _________________

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

Dose: _________________

OR

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:__________________________________

❒**Student may self-carry** ❒**Student may self-administer**

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

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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