LYNDHURST PUBLIC SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

Anaphylaxis Emergency Medical Care Plan

Student Name: _____ DOB _____ Grade _____

ALLERGY TO: _____

Describe prior reaction: _____

Asthmatic: ☐ Yes ☐ No

To Be Completed by Physician Only

This child's previous reactions(s) ☐ **could** ☐ **could not** be described as anaphylaxis.

Symptoms of Allergic Reaction/Anaphylaxis:

Skin: hives, welts, swelling of face or extremities	Lungs: shortness of breath, wheeze, cough
Nose: running, itching, congested	GI: cramps, abdominal pain, vomiting, diarrhea
Mouth: itching, swelling of lips, tongue, mouth	Brain: anxiety, agitation, loss of consciousness
Throat: tightness, trouble speaking, trouble breathing	

In the event of an allergic reaction, the **school nurse** should proceed as follows:

Give Benadryl _____ mg by mouth for _____
Observe closely for additional symptoms. Notify parent.

Give Epinephrine IM ☐ 0.15 mg or ☐ 0.30 mg for _____-_____
Call 9-1-1. Notify parent

When the **school nurse is unavailable** (field trip, athletics, after-school activities):

☐ Able to self medicate. Student has been trained and is allowed to self-administer Epinephrine by auto-injector ☐ antihistamine pre-measured dose at same time

☐ Unable to self-medicate
This child is not able to self-medicate. In the event of an anaphylactic reaction when the nurse is unavailable, I give my permission for a trained delegate to immediately administer a single dose of Epipen, and call 9-1-1.
I understand that under NJ State Law, the delegate is not permitted to give Benadryl.

_____ _____
Physician's Signature plus MD STAMP Date

As the parent/guardian, I shall indemnify and hold harmless the school district and its employees for any injury arising from the administration of a single-dose, pre-filled auto-injector of epinephrine to my child. I agree with the plan as developed by my child's physician, and I will provide the prescribed medications.

_____ _____
Parent/Guardian Signature Date