



Anaphylaxis Individual Emergency Care Plan

TO BE COMPLETED BY THE PARENT/GUARDIAN

Student's Name: _____ Date of Birth: _____

I request that my child be permitted to self-medicate as authorized by me and my child's physician. I understand that this authorization is effective only for the present school year and must be renewed for each subsequent year. I understand that Mercer County School District shall incur no liability as a result of any injury arising from the self-medication and that I hold harmless the district and its employees against any claims arising out of the self-administration of medication. I agree to indemnify and hold harmless the district and their employees or agents against any claims arising out of the self-administration of medication. **I understand that before my child will be permitted to self-administer medication, I must provide the school nurse with an epi-pen that my child will be carrying and self-administering. I understand that I am responsible for collecting the emergency medication at the end of the school year and should I not collect the medication it will be properly disposed.**

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN'S OFFICE

Allergy to: _____

This reaction could / could not be described as anaphylactic. Presenting symptoms include:

Please check off the appropriate symptoms:

- | | |
|--|---|
| <input type="checkbox"/> Skin: "hives" (red blotches or welts which itch): severe swelling | <input type="checkbox"/> Throat: tightness, trouble speaking, and trouble breathing |
| <input type="checkbox"/> Eyes: tearing, redness, itching | <input type="checkbox"/> Nose: running, itching, congested |
| <input type="checkbox"/> Lungs: shortness of breath, rapid breathing, cough, wheeze | <input type="checkbox"/> Mouth: itching, swelling of lips, tongue, or mouth |
| <input type="checkbox"/> Gut: repeated vomiting, nausea, abdominal pain (diarrhea later) | <input type="checkbox"/> Heart/Circulation: weak pulse, loss of consciousness |
| <input type="checkbox"/> Brain: anxiety, agitation, or loss of consciousness | |

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

1. If the child develops only hives (only skin problems) give antihistamine.
 - a. Dose: **Benadryl _____mg** by mouth
Oral antihistamine must be given only by nurse or parent.
 - b. Observe closely for additional symptoms; notify parent/guardian
2. If the child develops any of the signs of severe reaction of anaphylaxis,
 - a. Inject **Epinephrine IM: Dose _____.15mg - _____.30mg**
 - b. This dose of IM Epinephrine may be repeated in 15 minutes if symptoms recur.
 - c. Give the above dose of Benadryl by mouth
 - d. Notify parent/guardian, and call 911
3. If wheezing occurs, treat with: _____

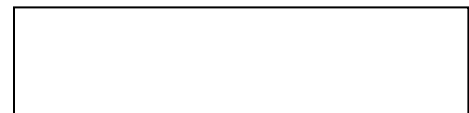
In the event of an allergic reaction when the school nurse is unavailable (field trips and/or school related activities)

Able to self medicate – I give my permission for this child to self-medicate when the school nurse is not available. I certify that _____ (student name) is capable of and has been instructed in the proper method of self-administering his/her medication including self assessment of symptoms and indications for administration. In the event that my child cannot self-medicate, I give my permission for a trained delegate to administer a single dose of an Epi-pen and call 911.

Unable to self medicate – This child is not able to self medicate at this time. In the event of an anaphylactic reaction when the nurse is not available, I give my permission for a trained delegate to administer a single dose of an Epi-pen and call 911. I understand that the delegate is not permitted by NJ State law to give Benadryl.

Physician's signature

Date



Office Stamp