

ALLERGY & ANAPHYLAXIS EMERGENCY PLAN

DATE OF PLAN: _____

Student Name: _____ Date of Birth (MM/DD/YY): _____ Age: _____

School: _____ Grade: _____ Weight _____ ☐ lbs. ☐ kg

History of anaphylaxis: ☐ Yes ☐ No Student has asthma: ☐ Yes (*higher risk for a severe reaction*) ☐ No

Student may: Self-carry medicine: ☐ Yes* ☐ No Self-administer medicine: ☐ Yes* ☐ No *By choosing yes, I confirm the student has received instruction on the indication for medication usage and the method of administration.

Allergies (please list): _____

IMPORTANT REMINDER: DO NOT depend on antihistamines or inhalers to treat a severe reaction. USE EPINEPHRINE.

For **ANY** of the following **SEVERE** SYMPTOMS



LUNG
Shortness of breath, wheezing, or coughing



HEART
Pale or bluish skin, fainting, weak pulse, or dizziness



THROAT
Tight or hoarse throat, trouble breathing or swallowing



MOUTH
Swelling of lips or tongue



SKIN
Many hives or redness over body



GUT
Repetitive vomiting or severe diarrhea



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

Or a **COMBINATION** of symptoms.

1. **ADMINISTER EPINEPHRINE IMMEDIATELY.** Note time epinephrine was given.
 2. **CALL 911.** Tell the emergency dispatcher the student is having anaphylaxis.
 3. **Stay with the student and monitor closely.** Alert emergency contacts and the student's healthcare provider.
 - If symptoms worsen or do not improve after five minutes, give a second dose of epinephrine.
 - Keep the student lying on their back. If the student vomits or has trouble breathing, keep the student lying on their side.
 4. **Give other medicine (if prescribed).**
 - Antihistamine/inhaler (bronchodilator) if wheezing.
- **Do not use other medicine in place of epinephrine. ****

MILD SYMPTOMS



NOSE
Itchy or runny nose, sneezing



MOUTH
Itchy mouth



GUT
Mild nausea or discomfort



SKIN
A few hives, mild itch

For **MILD SYMPTOMS** from **MORE THAN 1 SYSTEM AREA**, GIVE EPINEPHRINE.

For **MILD SYMPTOMS** from **A SINGLE SYSTEM AREA**, follow the directions below:

1. Give antihistamine (if prescribed).
2. Stay with the student and monitor closely for changes. If symptoms worsen, give epinephrine.
3. Alert emergency contacts.

☐ Check here if the student has an extremely severe allergy and should be given epinephrine at the first sign of any symptoms, even if mild.

MEDICATIONS/DOSES

Epinephrine (list type): _____

Epinephrine Dose: ☐ 0.1mg IM (intramuscular) ☐ 0.15 mg IM
☐ 0.3 mg IM ☐ 1 mg IN (intranasal) ☐ 2mg IN

Antihistamine, by mouth (type and dose): _____

Other (type/dose/route): _____

Additional Instructions/Comments: _____

EMERGENCY CONTACTS

Health Care Provider:	Parent/Guardian:	Other (Name/Relationship):
Phone:	Phone:	Phone:
Printed Name of Parent/Guardian	Parent/Guardian Signature	Date
Printed Name or Stamp of Health Care Provider	Health Care Provider Signature	Date
Printed Name of School Nurse (per policy)	School Nurse Signature (per policy)	Date

Parents must sign front and back of form.

ALLERGY & ANAPHYLAXIS EMERGENCY PLAN

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse has permission to communicate with the healthcare provider regarding this medication and plan of care including, but limited to, orders, clarification of orders, etc. I understand that the healthcare provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on need-to-know basis to those individuals who are involved in providing for your child’s health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Johnson City School System., the undersigned parent or guardian hereby understand and agrees that the Johnson City School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication. I, the undersigned parent or guardian hereby understand and agree that Johnson City Schools and its personnel shall not be liable for and injury resulting form the student’s self-administration of the medication, if applicable per health care provider’s selection above, while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct. I will notify extra-curricular staff about the health plan and care to be given during after school activities, if applicable. By signing, parent indicates agreement with the individual health plan as described by healthcare provider.

Printed Name of Parent/Guardian	Parent/Guardian Signature	Date