

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 epinephrine: ☐ Yes* ☐ No Self-administer epinephrine: ☐ 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.

- ADMINISTER EPINEPHRINE IMMEDIATELY.**
Note time epinephrine was given.
- CALL 911.** Tell the emergency dispatcher the student is having anaphylaxis.
- 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.
- 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
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For **MILD SYMPTOMS** from **MORE THAN 1 SYSTEM AREA**, GIVE EPINEPHRINE.

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

- Give antihistamine (if prescribed).
- Stay with the student and monitor closely for changes. If symptoms worsen, give epinephrine.
- 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: ☐ 0.1 mg IM (intramuscular) ☐ 0.15 mg IM
☐ 0.3 mg IM ☐ 1 mg IN (intranasal) ☐ 2 mg 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

Student Name _____
School/Teacher _____

Date of Birth: _____

Franklin Special District Allergy and Anaphylaxis Action Plan

PARENT/GUARDIAN TO COMPLETE THE SECTION BELOW

Student Name: _____
Father's Name: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Mother's Name: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Emergency Contact if parent not available: _____
(Authorized to act in behalf of parents if we are unable to contact parent)
Home Phone: _____ Cell: _____ Work Phone: _____
Physician Name: _____ Phone: _____ Fax: _____

Please describe a brief history of previous reactions and dates of reaction that your child has had to this food allergen.. Describe the symptoms and treatment that was required for the reaction(s).

My child ____ WILL ____ WILL NOT (check one) possess an epinephrine auto-injector (provided by the parent/guardian) to self-administer on school property or at school events according to this healthcare plan. I release FSD or its employees from liability as a result of my child's failure to carry or administer the medication according to the physician order in this healthcare plan.

-Epinephrine auto-injector (provided by parent/guardian) ____ WILL ____ WILL NOT be carried by my child on Bus # ____.

-Epinephrine auto-injectors are to be provided by the parent/guardian to be kept at school and be available for the student during the school day and on field trips. In the event a serious allergic reaction (anaphylaxis) occurs and no Epinephrine auto-injector is available, 911 will be called.

-Expired medications will not be administered and an unexpired autoinjector should be promptly provided by the parent/guardian.

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I understand that health information regarding my child will be kept confidential, but shared with school staff on a need to know basis in order to protect the health and safety of my child during the school day.

I understand that my child is competent to self-administer his/her medications with assistance from the school nurse or other designated, trained employee. I release the Franklin Special District from any legal claim and assume full responsibility for any adverse reactions my child may suffer as a result of taking or failing to take the medication. I understand my child will be administered medications and emergency treatment as indicated by the physician orders on the other side of this form. This treatment will be administered even if a parent/guardian cannot be reached. The physician providing medication orders on the other side of this form has my permission to provide this and other information regarding my child's health to the school nurse, principal or designated assistive personnel. The school nurse has my permission to speak with my child's physician regarding this plan and related health issues.

I understand and agree that my child may be assisted with medication administration/procedures on field trips or in the absence of a school nurse by unlicensed trained personnel (such as a teacher). I understand that if emergency medications have not been provided by the parent/guardian, 911 will be called.

Parent/Guardian Name

Parent/Guardian Signature

Date

Nurse Name

Nurse Signature

Date