Washington Township School District

ANAPHYLAXIS EMERGENCY CARE PLAN

place picture here

Name:______________________________D.O.B.__________ GRADE/TEACHER:__________

Allergy to:____

Weight: _____lbs Asthma: ☐**Yes** (higher risk for severe reaction) ☐No History of Anaphylaxis: ☐**Yes** ☐No

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

- LUNG-shortness of breath, wheezing, repetitive cough
- HEART-pale or bluish skin, faintness, weak pulse, dizziness
- THROAT-tight hoarse throat, trouble breathing or swallowing
- MOUTH-significant swelling of the lips or tongue
- SKIN-many hives over body, widespread redness
- GUT-repetitive vomiting, severe diarrhea
- OTHER-feeling something bad is about to happen, anxiety, confusion
- Or a combination of symptoms from different body areas

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1. **INJECT EPINEPHRINE IMMEDIATELY**
2. **CALL 911**. Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
3. Consider giving additional medications following epinephrine:
   - Antihistamine
   - Inhaler (bronchodilator) if wheezing
4. Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let him/her sit up or lie on side.
5. If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
6. Alert emergency contacts.
7. Transport person to Emergency Room, even if symptoms resolve.
8. Treat the person before calling emergency contacts. Mild symptoms can worsen.

MILD SYMPTOMS

- NOSE-itchy or runny nose, sneezing
- MOUTH-itchy mouth
- SKIN-a few hives, mild itch
- GUT-mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE SYSTEM**, **GIVE EPINEPHRINE.**

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. **If symptoms worsen, give Epinephrine.**

MEDICATIONS/DOSES

Epinephrine Brand or Generic:____________________

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Dose:________________________

According to NJ State Law, orders for antihistamines alone cannot be self-administered

Additional Medication:______________________

PERMISSION TO SELF-ADMINISTER:

☐ This student has been trained and **is capable of self-administration** of the medications noted above in accordance with NJ Law, N.J.S.A.:18A:40-12.3-12.6. The student shall carry the medication(s) at all times in school and at all school-sponsored events and activities.

☐ This student is not approved to self-medicate.

PHYSICIAN SIGNATURE:_________________________Date:__________

PHYSICIAN STAMP:

EMERGENCY CONTACTS-CALL 911

DOCTOR:___________________________PHONE:______________

PARENT/GUARDIAN:___________________PHONE:______________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP:___________________ PHONE:____________

NAME/RELATIONSHIP:___________________ PHONE:____________

I give consent for administration of the above noted medications to be given by the school nurse (or delegate as per P.L.2007,c.57). The school district and its employees or agents shall incur no liability as a result of any injury arising from the administration or self-administration (if applicable) of the above noted medications to my child. I shall indemnify and hold harmless the district, its employees, and agents against any claims arising out of the administration or self-administration (if applicable), or my child's possession (if applicable), of the above noted medication(s). If the student is able to self-administer, **I understand my child shall keep the medication(s) prescribed for self-administration with him/her at all times** in school and at all school-sponsored events and activities. I hereby give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medication. I understand that this information will be shared with school staff/faculty. This consent is only valid for the school year in which this form was completed.

_____I consent to having delegate(s) assigned for my child. I understand that a list of my child's delegate(s) is available for review in the Nurse's office.

PARENT/GUARDIAN SIGNATURE:____Date:___________

For **self-administration** only: _____ I will provide the school nurse with back up medication(s)

_____ I will **NOT** provide the school nurse with back up medication(s)

If your child can not self-administer you **MUST provide the school nurse the prescribed medication(s)**