

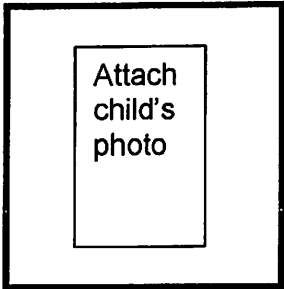
Allergy and Anaphylaxis Emergency Plan

Child's name: _____ Date of plan: _____

Date of birth: ___/___/___ Age ___ Weight: _____ kg

Child has allergy to _____

- Child has asthma. Yes No (If yes, higher chance severe reaction)
 Child has had anaphylaxis. Yes No
 Child may carry medicine. Yes No
 Child may give him/herself medicine. Yes No (If child refuses/is unable to self-treat, an adult must give medicine)



IMPORTANT REMINDER

Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

<p>For Severe Allergy and Anaphylaxis What to look for</p> <p>If child has ANY of these severe symptoms after eating the food or having a sting, give epinephrine.</p> <ul style="list-style-type: none"> • Shortness of breath, wheezing, or coughing • Skin color is pale or has a bluish color • Weak pulse • Fainting or dizziness • Tight or hoarse throat • Trouble breathing or swallowing • Swelling of lips or tongue that bother breathing • Vomiting or diarrhea (if severe or combined with other symptoms) • Many hives or redness over body • Feeling of "doom," confusion, altered consciousness, or agitation <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p>_ SPECIAL SITUATION: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, give epinephrine.</p> </div>	<p style="text-align: center;">➔</p> <p>Give epinephrine! What to do</p> <ol style="list-style-type: none"> 1. Inject epinephrine right away! Note time when epinephrine was given. 2. Call 911. <ul style="list-style-type: none"> • Ask for ambulance with epinephrine. • Tell rescue squad when epinephrine was given. 3. Stay with child and: <ul style="list-style-type: none"> • Call parents and child's doctor. • Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes. • Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side. 4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine. <ul style="list-style-type: none"> • Antihistamine • Inhaler/bronchodilator
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<p>For Mild Allergic Reaction What to look for</p> <p>If child has had any mild symptoms, monitor child. Symptoms may include:</p> <ul style="list-style-type: none"> • Itchy nose, sneezing, itchy mouth • A few hives • Mild stomach nausea or discomfort 	<p style="text-align: center;">➔</p> <p>Monitor child What to do</p> <p>Stay with child and:</p> <ul style="list-style-type: none"> • Watch child closely. • Give antihistamine (if prescribed). • Call parents and child's doctor. • If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")
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Medicines/Doses

Epinephrine, intramuscular (list type): _____ Dose: 0.15 mg 0.30 mg (weight more than 25 kg)

Antihistamine, by mouth (type and dose): _____

Other (for example, inhaler/bronchodilator if child has asthma): _____

Parent/Guardian Authorization Signature _____ Date _____

Physician/HCP Authorization Signature _____ Date _____

Allergy and Anaphylaxis Emergency Plan



Child's name: _____ Date of plan: _____

Additional Instructions:

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

I approve the above Emergency Care Plan and request school personnel to follow the above plan in the event of an emergency involving my child. I will notify the school immediately if my child's health status changes or if there is a change or cancellation of his Emergency Care Plan.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the School Board, the individual members thereof and any officials or employees involved in the rendering of care in accord with the above Emergency Care Plan from any claims or liability or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of care in accord with the above Emergency Care Plan.

Contacts

Call 911 / Rescue squad: () _____ - _____

Doctor: _____ Phone: () _____ - _____

Parent/Guardian: _____ Phone: () _____ - _____

Parent/Guardian: _____ Phone: () _____ - _____

Other Emergency Contacts

Name/Relationship: _____ Phone: () _____ - _____

Name/Relationship: _____ Phone: () _____ - _____