Harrison County School Health Clinic

EMERGENCY ACTION PLAN

Confidential

Student Name:_____

Date of Birth:_____

Date of Implementation:_____

This EAP is appropriate for use for ONE YEAR from the date of implementation.

EMERGENCY ACTION PLAN

Harrison County School Health Clinic

STUDENT INFORMATION

Student Name:_____ **DOB**_____ **YEAR**_____

SCHOOL:_____ GRADE:_____ TEACHER:_____

Student's address:_____ PHONE:_____

Medication Allergies or OTHER Allergies: _____

_____

Mother's/ Guardian's Name:_____

Phone: (H)_____ **(C)**_____ **(W)**_____

Father's / Guardian's Name: _____

Phone:(H)_____ **(C)**_____ **(W)**_____

Emergency Contact #1: _____

Phone:_____

Relationship: _____

Emergency Contact #2:_____

Phone: _____

Relationship: _____

Provider's Name: _____

Date last seen: _____

Phone: _____

Provider's Address:_____

HEALTH CONDITION: (Diabetes, Asthma, Seizures, Severe Allergy, Other	Medications	Care needed at school. PLAN INITIATED

Other information or instructions: _____

_____

Nurse Signature	Person Interviewed	Date: Initial Interview and yearly updates

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Attach child's photo

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-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine.**

- 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

☐ **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.**

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - 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.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- 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.")

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**

 Your child's doctor will tell you to do what's best for your child. This information should not take the place of talking with your child's doctor.

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Child's name: _____ Date of plan: _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: (___) _____-_____

Doctor: _____ Phone: (___) _____-_____

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

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

Other Emergency Contacts

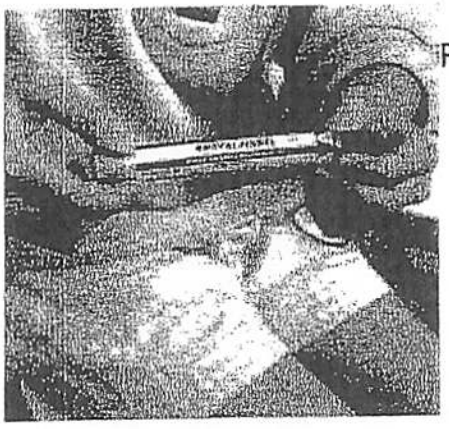
Name/Relationship: _____ Phone: (___) _____-_____

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

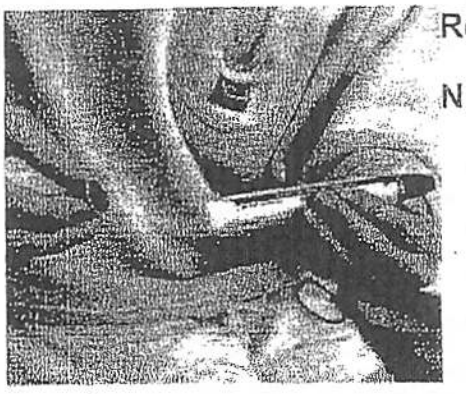
 Your child's doctor will tell you to do what's best for your child. This information should not take the place of talking with your child's doctor.

EpiPen Administration ALLERGY Emergency Action Plan
CALL 911.....

Name_____ Date of Birth_____

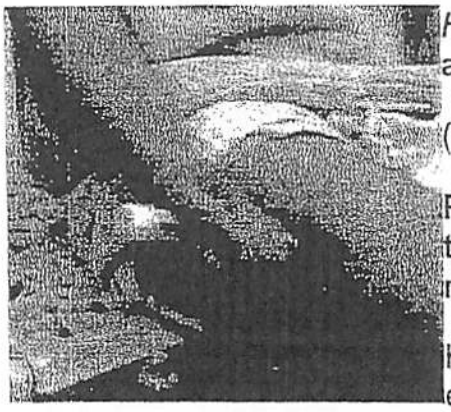


Remove the device from the plastic protective container.



Remove the *grey cap* from the fatter end of the device.

NB: This "arms the unit" ready for use



Hold the EpiPen in your fist with clenched fingers wrapped around it

(NB: there is nothing to "push" at the white end)

Press the *black tip* gently against the skin of the mid thigh, then start to push harder until a loud "click" is heard. This means that the device has been activated.

Hold in place for 10-15 seconds (count "1 elephant, 2 elephants, 10 elephants etc") while the adrenaline is injected under pressure.

NB: The EpiPen "pop" is often quite loud.

Harrison County School Health Clinic
Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____ School Year: _____ Date form received: _____
I acknowledge receipt of this Physician's Statement and Parent Authorization: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Student Name _____ **Date of Birth** _____

Name of Medication: _____

Reason for Medication: _____

Allergies: _____

Form of Medication: □ Tablet/Capsule □Liquid □Inhaler □Injection □Nebulizer □Other _____
Instructions (Schedule and dose to be given at school): _____

_____

Start Date: □ Date Form Received □ Other _____
Stop Date: □ End of School Year □ Other date/duration: _____
□**For episodic/emergency events only**

Restrictions and/or important side effects: □ NO Restrictions
□Yes (please describe) : _____

_____

Special Storage Requirements: □ None □ Refrigerate □ Other: _____

Physician Signature _____ Physician's Name _____
Date _____ Phone _____ Address _____

*****FOR SELF ADMINISTRATION ONLY*****

Pursuant to KRS 158.832 to KRS 158-836 Harrison County Schools permits a student to possess and self-administer asthma, diabetes or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian.

This student has been instructed on self-administration of this medication: **(to be completed for asthmatic, diabetic, or severe allergic reaction (anaphylaxis) ONLY):**
□ NO □ Supervision required □ Supervision NOT required

This student may carry this medication: □ YES □ NO

Please indicate if you have provided additional information:
□ On the back side of this form □ As an attachment
Physician Signature _____ Date _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) _____ to receive the above stated medication at school according to the standard school policy. I release the **Harrison County School Board** and its employees from any claims or liability connected with its reliance on the permission.
(Parent/Guardian to bring the medication in its original container.)

Date _____ Name: _____ Signature _____

Relationship to Child: _____

Home Phone: _____ Work Phone: _____
Other Emergency Contact Name: _____ Phone: _____