Allergy and Anaphylaxis Emergency Plan

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

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: ☐ 0.10 mg (7.5 kg to 15 kg)
☐ 0.15 mg (15 kg to 25 kg)
☐ 0.30 mg (25 kg or more)

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**

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EMERGENCY CONTACT INFORMATION

#1 Emergency contact: Name_________________________________ relationship_________________________

home_________________________ work______________________ cell________________________________

#2 Emergency contact: Name__________________________________ relationship________________________

home_________________________ work______________________ cell________________________________

#3 Emergency contact: Name__________________________________ relationship_________________________

home_________________________ work______________________ cell_______________________________

Additional Comments:

____

____

____

Doctor's Name and Phone Number:____

____

Nurse's Signature:____Angela Murphy RN,BSN

Phone: 508-543-1630 In House Ext: 55410 Date:_________________

Parent's Signature:____Date:________________

(for individuals under age 18 yrs)

This information is for general purposes and is not intended to replace the advice of a qualified health professional. For more information, visit www.aaaai.org. © 2017 American Academy of Allergy, Asthma & Immunology

PARENT/GUARDIAN AUTHORIZATION: EPI-PEN MEDICATION ADMINISTRATION: TRANSPORTATION/CAFETERIA/FIELD TRIP

Bus Transportation

Students may keep a prescribed EpiPen in their backpack for coverage on the bus to and from school. The bus drivers will be alerted to your child's allergy and they will be trained by a nurse to administer the Epi Pen. We recommend that you tell them about the Epi Pen/Allergies on the first day of school!

I give permission for the bus driver on bus #__________ to administer a prescribed EpiPen to my child, __________________________________ **(print name)** in the event of an allergic reaction.

I understand that if I choose to put an Epi Pen in my child's back pack, it is my responsibility to provide an Epi Pen with a valid expiration date and to check that it is in my child's backpack daily. It must be clearly labeled with the child's name and have a prescription label attached. Please ask the pharmacist to attach the prescription label directly to the Epi Pen. **A picture ID is strongly recommended.** ***Please initial:***____________

Cafeteria; Field Trip; Emergency

I give permission for a staff member designated and trained by the school nurse to administer an Epi Pen to my child in the cafeteria, classroom, on a field trip, or in any emergency. The same holds true for an inhaler or daily medication that may be ordered on the front page of this form. I understand that, per the Massachusetts Department of Public Health regulation, no PRN [as needed] medication (e.g. Benadryl) will go on field trips.

Please initial :___________

Peanut/Nut Free Tables in the Cafeteria

Please check ONE option below:

☐ I WISH for my child to sit at the **designated peanut/tree nut free table** during lunch in the cafeteria.

☐ I DO NOT wish for my child to sit at the designated peanut/tree nut free table during lunch in the cafeteria. They may sit anywhere they choose. ***Please initial:***_____________

Please check ONE option below! (Check all staff that apply)

☐ I would prefer that information regarding my child's allergy BE SHARED with the following staff:

All cafeteria staff:______**Classroom teacher:** _______**Bus driver (transportation office):** _______***Please initial:***________

☐ I would prefer that information regarding my child's allergy NOT BE SHARED with the following staff:

All cafeteria staff:______**Classroom teacher:** _______**Bus driver (transportation office):** _______***Please initial:***________

Please sign below:

____ ________________

Parent/Guardian Signature ***Date***

Note: *Students with severe allergies or medical conditions are encouraged to wear* ***MedicAlert*** *identification.*