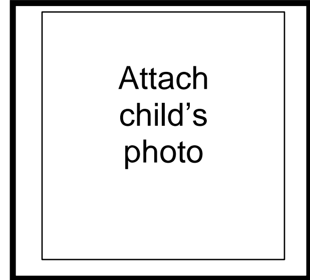
Allergy and Anaphylaxis Emergency Plan

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-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**.

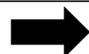
- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- 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 more than 1 symptom or 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 less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): ______________________________ (*Use 0.15 mg, if 0.10 mg is not available)

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

______________________________ ____________ ______________________________ ____________
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

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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: _____________________

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Guthrie Public Schools
Parental Authorization to Administer Medicine or Assist with Application of Sunscreen

TO: ______________________________ ______________________________
(Administrator) (School)

I am the parent, guardian or legal custodian with legal custody of ______________________, a minor student attending this school.

☐ This student requires medication (not including sunscreen) at intervals during the school day. I hereby give my consent and authorize the school nurse, the principal, or ______________ (an employee of the School District designated by the school nurse, the principal, and me) to administer:

☐ (name of drug) ______________________, a non-prescription medication which I am hereby supplying you, in accordance with my written instructions or the written instructions of a physician which are attached hereto.

☐ (name of drug) ______________________, a filled prescription medication which I am hereby supplying you, in accordance with the directions for the administration of the medicine listed on the label of the vial.

☐ (name of drug) ______________________, a filled prescription medication which I am hereby supplying you, in accordance with the written instructions of the physician prescribing the medicine, which is attached hereto.

☐ I hereby give my consent and authorize my child to self-medicate under the School District's Policy on the Administration of Medicine to Students.

☐ I desire that the school assist the student in applying sunscreen. I understand that the student may possess and self-apply sunscreen without my written authorization. I hereby give my consent and authorize the school nurse, the principal, or _________________ (an employee of the School District designated by the school nurse, the principal, and me) to assist the student in applying sunscreen:

☐ sunscreen, which I am hereby supplying you, in accordance with the label directions.

☐ sunscreen, which I am hereby supplying you, in accordance with written instructions of the student's physician which I have attached.

I understand that under state law the Board of Education, the School District, or employees of the School District shall not be liable to the student or the student's parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees in administering the medicine or assisting in the application of sunscreen I have hereby authorized. I understand that the School District, its agents and employees shall incur no liability for any adverse reaction or injury suffered by the student as a result of the self-administration of medication and/or using the specialized equipment.

I agree to abide by all of the terms of the School District's Policy on the Administration of Medicine to Students, a copy of which will be given to me on my request.

______________________________ ______________________________
Date Signature

______________________________ ______________________________
Address Parent with legal custody/guardian

Guthrie Public Schools
MEDICATION AUTHORIZATION

Student: ______________________ **Birthdate:** __________ **Grade:** ____ **School:** ______________

Parent/Guardian: ______________________ **Phone:** ______________________ **Date:** ___________

PRESCRIPTIONS TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

- Reason for medication ______________________________
- Name of medication ______________________________
- Dosage ______________________________
- Time and Route to be administered ______________________________
- Duration (week, month, indefinite, etc.) ______________________________
- Possible side effects ______________________________

______________________________ ______________ ______________
Physician/Licensed Prescriber's Signature Office Phone Date

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN:

I hereby request and give my permission for the above-named school to administer the medication authorized on this form to my child. I understand that I am responsible for maintaining the supply and picking up any remaining medication at the end of the school year; medication will not be sent home with students. Medication remaining after the school year has ended will be discarded utilizing proper procedure. I give my permission to the school nurse/designated employee to consult with the prescriber regarding this prescription.

______________________________ ______________________
Parent/Guardian Signature Date

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COMPLETE ONLY FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION, ANAPHYLAXIS MEDICATION, OR REPLACEMENT PANCREATIC ENZYMES

TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

- This student has been instructed in the proper use of his/her medication. It is my professional opinion that this child is both capable and responsible of self-administering this medication and shall be allowed to carry this medication on his/her person. Yes ☐ No ☐

______________________________ ______________________
Physician/Licensed Prescriber's Signature Date

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN:

I hereby give my consent and authorize my child to self-administer and/or self-carry his/her medication at school.
I will provide an emergency supply of this medication to be administered by school personnel, as required by State law.

______________________________ ______________________
Parent/Guardian Signature Date

I will not knowingly share my medication with another student.

______________________________ ______________________
Student Signature Date

It is Guthrie Public Schools policy that medication and sunscreen will only be administered by school staff with written authorization of the child's legal custodian and/or written instructions from the child's physician. Medication must be in the original container with proper labeling: child's name; medication name, strength, and expiration date; dosage and instructions for administration; name of licensed prescriber/physician; pharmacy name, address, and phone number. Authorization forms must be completed annually for each medication, and for any changes to dose/administration time. School staff will not administer medication or sunscreen that is not in the original container, improperly labeled, unauthorized, or expired. Medication must be brought to school by a parent/legal guardian.

Receiving Employee: ______________________ Date: ______________________