Individualized Emergency Care Plan for Allergic Reaction

Child's Photo

Student's Name_____D.O.B_____Grade/Teacher_____

ALLERGY TO: _____

Asthmatic Yes ( )* No ( ) *Higher risk for severe reaction

Previous Episode of Anaphylaxis Yes ( ) No ( ) If yes when? _____

TREATMENT – to be filled out by healthcare professional

(If the student is experiencing the following symptoms, administer the appropriate medication)

Symptoms	**Give Checked Medication** (To be determined by physician authorizing treatment)
Mouth - Itching, tingling, or swelling of lips, tongue, mouth	( ) Epinephrine ( ) Antihistamine
Skin - Hives, itchy rash, swelling on face or extremities	( ) Epinephrine ( ) Antihistamine
Gut - Nausea, abdominal cramps, vomiting, diarrhea	( ) Epinephrine ( ) Antihistamine
General - Panic, sudden fatigue, chills, fear of impending doom	( ) Epinephrine ( ) Antihistamine
Throat † - Tightening of throat, hoarseness, hacking cough	( ) Epinephrine ( ) Antihistamine
Lung † - Shortness of breath, repetitive coughing, wheezing	( ) Epinephrine ( ) Antihistamine
Heart † - Thready pulse, passing out, fainting, pale, blueness	( ) Epinephrine ( ) Antihistamine
Other † - _____	( ) Epinephrine ( ) Antihistamine
If reaction is progressing (several of the above areas affected) †	( ) Epinephrine ( ) Antihistamine
If food allergen has been ingested, but no symptoms	( ) Epinephrine ( ) Antihistamine

† *Potentially life-threatening*

DOSAGE

Epinephrine: Inject intramuscularly (circle one): EpiPen EpiPen Jr.
Twinject 0.3 mg Twinject 0.15 mg

Antihistamine: give_____
Medication/dose/route

Other: give _____
Medication/dose/route

Please check one of the following:

1. ☐ This student has been trained and is capable of self-administration of the following medication(s) named above. ☐ epinephrine – single dose unit ☐ Epinephrine & antihistamine – single dose units

2. ☐ This student is not capable of self-administration of the medications named above.

Physician's signature _____

Phone number _____

Date_____ Stamp _____

Please note - In the absence of a school nurse, a trained delegate will give epinephrine and any antihistamine order will be disregarded.

For School Use:

TRAINED STAFF MEMBERS/Room#

_____/_____
_____/_____
_____/_____
_____/_____
_____/_____

LOCATION OF EPINEPHRINE

[ ] Nurse's Office_____
[ ] Principal's Office _____
[ ] Student_____
[ ] Classroom(s)_____
[ ] Other_____

PARENT: Select one to sign and date.

1. I verify that my child _____ has a potentially life threatening illness and **has been instructed in self-administration** of the prescribed medication in a life threatening situation. **I hereby give permission for my child to self-administer the prescribed medication**. If your child is unable to self-administer at the time of reaction, the nurse, or a delegate will administer the medication. I understand that under NJ state law a trained delegate will be assigned to administer epinephrine to my child in the absence of the school nurse. Under law, a delegate may not give antihistamines. In the absence of the school nurse, any antihistamine order will be disregarded and the trained delegate will administer epinephrine.

_____ _____

Signature of Parent/Guardian Date

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2. I verify that my child _____ has a potentially life threatening illness and is **unable to self-administer** the prescribed medication in a life threatening situation. I hereby request that the school nurse or delegate administer the prescribed medication. I understand that under NJ state law a trained delegate will be assigned to administer epinephrine to my child in the absence of the school nurse. Under law, a delegate may not give antihistamines. In the absence of the school nurse, any antihistamine order will be disregarded and the trained delegate will administer epinephrine.

_____ _____

Signature of Parent/Guardian Date

Checklist for parent use:

☐ I have supplied the school nurse with a completed and signed emergency care plan for allergic reaction including a photo of my child.

☐ Epinephrine auto-injector was supplied to my child or the classroom with a valid expiration date. Expiration date____/____/____. In middle school the student will carry the epi-pen with him, and in lower school, the teacher, parent, student and nurse will decide who is responsible for carrying the epi-pen.

☐ One spare Epinephrine auto-injector device with valid expiration date was supplied to the school nurse for inclusion in the emergency kit for nurse or delegate to administer as needed.

☐ I have informed my child's bus driver if he rides the bus.

☐ I have reminded my child to keep one dose of epinephrine with him at all times.

☐ I have reminded my child to keep one dose of antihistamine with him/her at all times.
or ☐ Antihistamine is not prescribed.

☐ When my child is in a club, staying after school, on a field trip, involved in sports or any other activity outside of the building, I will inform the person in charge of that activity/event of my child's allergy.

☐ The school has been provided with up-to-date emergency contact information.