Pen exp.:_____

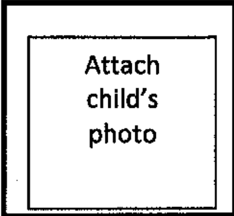
Anti. exp.:_____

Inhaler exp.:_____

Allergy and Anaphylaxis Emergency Plan

Name:	Date of Birth:	Weight: lbs / kg
Date of Plan:	Age:	
ALLERGIES:		

Child has asthma: yes / no (if yes, higher chance of a severe reaction)
Child has had anaphylaxis: yes / no (if yes, higher chance of a severe reaction)
Child may carry medicine: yes / no
Child may give him/herself medicine: yes / no (if child refuses, an adult must give medicine)



☐ **The "Always-Epinephrine" Option:** If checked, **give epinephrine** immediately, if the child has ANY symptom (mild or severe) after a sting or eating a food listed above. (Option advised for those schools where a nurse is not always present.)

****IF IN DOUBT, GIVE EPINEPHRINE!** ANAPHYLAXIS is a potentially life-threatening, severe allergic reaction

For SEVERE Allergy or Anaphylaxis	**Give EPINEPHRINE!**
What to look for: If child has ANY of these symptoms after eating a food or having a sting, **give epinephrine** ➢ Breathing: trouble breathing, wheeze, cough ➢ Throat: tight or hoarse throat, trouble swallowing or speaking ➢ Brain: confusion, agitation, dizziness, fainting, unresponsiveness ➢ Gut: severe stomach pain, vomiting, diarrhea ➢ Mouth: swelling of lips or tongue that affects breathing ➢ Skin: many hives or redness over body, face color is pale or blue	**What to do:** 1. **Inject epinephrine right away!** Note the time. 2. Call 911 • Ask for ambulance with epinephrine • Tell rescue squad when epinephrine was given 3. Stay with child and: • Call parents • **Give a second dose of epinephrine** if symptoms worsen 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 their side 4. Give other medicine (e.g. antihistamine, inhaler) if prescribed. Do not use other medicine in place of epinephrine.

For MILD Allergic Reaction	**Give Antihistamine and Monitor the Child**
What to look for: If child has mild symptoms, or no symptoms but a sting or ingestion of the food is suspected, give antihistamine and monitor the child. Mild symptoms may include: ➢ Skin: a few hives, mild rash, mild swelling, OR ➢ Mouth/nose/eyes: itching, rubbing, sneezing, OR ➢ Gut: mild stomach pain, nausea or discomfort Note: if the child has more than one mild symptom area affected, **give epinephrine**	**What to do:** 1. Give antihistamine if prescribed 2. **If in doubt, give epinephrine** 3. Call parents 4. Watch child closely for 4 hours 5. **If symptoms worsen, give epinephrine** (See "For SEVERE Allergy and Anaphylaxis")

Medicine/Doses

Epinephrine (intramuscular in thigh): ▫ 0.1 mg ▫ 0.15 mg ▫ 0.30 mg

Antihistamine (by mouth): ▫ Diphenhydramine _____mg (_____ml) ▫ Other__________: _____ mg (_____ml)

Other medications: ▫ Albuterol 4 puffs ▫ other: ______________

PROVIDER Signature **Date** **Name (printed)** **Phone** **NPI#**

PARENT/GUARDIAN Signature **Date** **Name (printed)** **Phone**

I authorize the school to follow Plan and contact the Health Care Provider, and release the school district and personnel from civil liability

Reviewed by school nurse: ______________________________ Date: __________ __________

Allergy and Anaphylaxis Emergency Plan

Child's name: ______________________________ Date of Plan: ____________________

Additional Instructions:

Contacts

Doctor name (print): ______________________________ Office Phone: (___) _____-______
Office Address: ______________________________ Office Fax: (___) _____-________
____
____

Parent/Guardian name (print): ______________________________ Phone: ______________________________

Parent/Guardian name (print) : ______________________________ Phone: ______________________________

Other Emergency Contacts

Name/Relationship: ______________________________ Phone: ______________________________

Name/Relationship: ______________________________ Phone: ______________________________

Reviewed by school nurse: ______________________________ Date: __________ __________

POWAY UNIFIED SCHOOL DISTRICT
15250 Avenue of Science, San Diego CA 92128

PARENT/STUDENT AUTHORIZATION FOR SPECIALIZED PHYSICAL HEALTH CARE SERVICE

I understand that only personnel meeting the requirements of California Education and Administration Codes will be performing the attached health care service and will be using only the standardized procedure approved by our physician.

I will provide the medicine(s) in the prescription container(s) which is labeled with the name of my child, the prescribing physician name, and amount of medication prescribed.

I understand that if the antihistamine is administered, the student must be sent home.

If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician.

Prescription and nonprescription medications are not permitted to be taken at school without a written statement from the physician *and* a written statement from the parent indicating desire that the district assist the student as set forth in the physician's statement.

I agree to save and hold the district, its officers, employees or agents, harmless from all liability, suits or claims, or whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

To facilitate the foregoing, I hereby grant permission for the exchange between our physician and the Poway Unified School District of that confidential medical information contained in my child's records necessary to accomplish this service.

I will notify the school immediately if the health status of my child changes, we change physicians, or there is a change in or cancellation of the procedure.

***I have read and accept conditions set forth by PUSD for treatment of Anaphylaxis and Parent Responsibilities in the PUSD Life Threatening Allergy Guidelines (above). I understand if an antihistamine is administered at school, the student will be sent home.**

STUDENT (ONLY IF SELF CARRY):
I understand the purpose, method, and frequency of use for my medication(s). I know that my medication(s) is not a toy, and that carrying my medication(s) with me requires that I act responsibly.

1. I will keep my medication(s) with me at all times
2. I will notify school staff if emergency medication(s) is used
3. I will not share my medication(s) with other students or friends
4. I will not play with my medication(s) in class or during school activities
5. I will not threaten others with my medication(s)

If I do not comply with the above behavioral expectations, I know that my parent/guardian will be notified and I will not be able to carry my medication(s) with me. If this happens other arrangements will be made for my emergency medication(s) while I am at school.

STUDENT SIGNATURE: ______________________ **Date:** ______________________

PARENT SIGNATURE: ______________________ **Phone**______________ **Date:** ______________

All Staff: Students with food allergies should not be given food unless it is provided or approved by parents. Parents may provide a container of safe treats for storage at school. It is advisable to limit the number of food events in your classroom. Classroom projects/crafts should be free of allergens. Children should be encouraged to wash hands before and after eating. Desks and surfaces should be wiped after food events in the classroom. Food should not be used as a reward. If there is a suspected exposure incident, contact the Health Technician and observe carefully. Reactions can be delayed! The severity of symptoms can quickly change.