

BYRON PUBLIC SCHOOLS #531
ANAPHYLAXIS EMERGENCY CARE PLAN

Student's name: _____ Grade/Teacher's name: _____

Known Allergies: _____

Does your child also have asthma? Yes _____ No _____ (If yes, higher risk for severe reaction)

Emergency Contacts:

Parent/Guardian #1: _____ Phone Number: _____

Parent/Guardian #2: _____ Phone Number: _____

Hospital in Case of Emergency: _____

Signs and Symptoms of Anaphylaxis:

Systems:

Symptoms:

MOUTH	itching & swelling of the lips, tongue, or mouth
THROAT*	itching and/or a sense of tightness in throat, hoarseness, and hacking cough
SKIN	hives, itchy rash, and/or swelling about the face or extremities
GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
LUNG*	shortness of breath, repetitive coughing, and/or wheezing
HEART*	"thready" pulse, "passing-out"

***The symptoms of a reaction are not always consistent and could include any of the above.**

***The severity of symptoms can quickly change.**

***All above symptoms can potentially progress to a life-threatening situation!**

Steps to Take During an Anaphylactic Event - Emergency Protocol

1. Remain calm. Reassure the student and do not leave them alone.
2. Notify the health office IMMEDIATELY and staff will bring the epinephrine.
3. **Inject epinephrine IMMEDIATELY** and note time when it was given.
4. **Call 911.** Request an ambulance and specify that the child is having an anaphylactic reaction; state your location in the school.
5. Give another epinephrine dose within 15 minutes if symptoms return or worsen and emergency services have not yet arrived.
6. Alert parent/guardian(s).

Physician's Authorization for Medication Administration

Epinephrine Device	Dosage	Time	Special Instructions

Self-Carry? Yes _____ No _____ *If yes, I understand this student will carry the above listed medication at school. I also understand this student will be entirely responsible for the use of this medication and use will not be monitored by school personnel.*

Other Pertinent Medication	Dosage	Time	Special Instructions

Physician's Signature X _____ **Date:** _____

Physician (Printed Name) _____ **Phone:** _____

Please see reverse side of this form for Parent Authorization and Self Administration Procedure

OVER→

Anaphylaxis Emergency Care Plan Continued:

Authorization For Staff Administration Of Medication Including when on Field Trips

I understand that trained school personnel will follow the Anaphylaxis Emergency Care Plan as completed by my child's physician, school nurse, and myself. Further, under the delegation of the LSN/RN, I hereby give my permission that trained school personnel can administer this emergency medication in the absence of a school nurse or if my child is away from the school on a field trip or other school activity during regular school hours. I release school personnel from any liability in relation to this request when the medication is given as ordered.

Parent/Guardian Signature: _____ Date: _____

Authorization to Share Health Information with Project Kids Child Care

☐ Not applicable

My child will be attending Project Kids on various days throughout the school year. I authorize that a copy of my child's Anaphylaxis Emergency Care Plan may be shared with the Project Kids program Supervisor(s) for collaboration and continuity of care during before and after school hours.

Parent/Guardian Signature: _____ Date: _____

Self-Administration Of Medication

☐ Not applicable

I hereby authorize my child to self-administer the above named medication(s) during school as prescribed by the physician. I have read the student agreement.

I understand that my child will carry this medication at school and use will not be monitored by school personnel. I understand that trained school personnel will follow the Anaphylaxis Emergency Care Plan as completed by my child's physician, school nurse, and myself should my child be unable to self-administer his/her medication.

Parent/Guardian Signature: _____ Date: _____

Student Agreement for Self-Administration of Medication

☐ Not applicable

I agree to:

- ☐ Follow my prescribing physician medication orders.
- ☐ Use correct medication administration techniques.
- ☐ Not allow anyone else to use my medication.
- ☐ Keep a supply of my medication with me in school and on field trips.
- ☐ Notify the school nurse or health office personnel if my epinephrine is administered and 911 will be called.
- ☐ Notify the school nurse or health office personnel if I have any exposure to allergy-causing food or substances or exhibit any symptoms of an allergic reaction.

Student Signature: _____ Date: _____

**The student has demonstrated knowledge about proper use of his/her medication (epinephrine) administration.

LSN/RN Signature: _____ Date: _____

This Anaphylaxis Emergency Care Plan has been reviewed.

LSN/RN Signature: _____ Date: _____

Updated 03/2022