Students

Exhibit – Allergy and Anaphylaxis Emergency Plan

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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: _____

Attach child's photo

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

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IMPORTANT REMINDER

Anaphylaxis is a potentially life threatening, 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 cough ● Skin color is pale or has 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 a 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 than 13 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 0.15mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child as asthma): _____

_____ _____

Physician/UCP Authorization Signature **Date**

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In the event of a medical emergency, I hereby authorize the School District and its employees and agents to administer or to attempt to administer to my child (or to allow my child to self-administer pursuant to State law, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine injectors and/or asthma medication, to the extent the School District maintains such undesignated supplies.

I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and by signing below, I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

The following is applicable only to parents/guardians of students who need to carry and use their epinephrine injector and/or asthma medication: *I authorize the School District and its employees and agents, to allow my child to self-carry and self-administer his or her epinephrine injector and/or asthma medication: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District to inform parents/guardians that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry and self-administration of an epinephrine injector or asthma medication.*

_____ _____

Parent/Guardian Authorization Signature Date

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structions:

Child's Name:
_____
_____
_____
_____
_____
Date of Plan:_
_____

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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