Jefferson Joint School District #251
Anaphylaxis/Severe Allergy Emergency Plan (AEP)

(For District Use)
Effective Date: ___________

Student Name: ________________________________ DOB: __________ School: ________________

Student has Allergy to: ____

Child has had Anaphylaxis. ❒ Yes ❒ No   Child has Asthma. ❒ Yes ❒ No (if yes, higher chance of severe reaction)

Rescue medications will be: ❒ Stored in Office ❒ In Possession of Student – Location:________________

Anaphylaxis is a potentially life-threatening, severe allergic reaction.
There are **no absolute contraindications** to the use of epinephrine in a life-threatening situation.
If in doubt, ADMINISTER EPINEPHRINE.

❒ If checked, **give epinephrine** immediately if the allergen was **LIKELY** eaten, for **ANY symptoms**.

❒ If checked, **give epinephrine** immediately if the allergen was **DEFINITELY** eaten, even if **no symptoms are apparent**.

Check for Symptoms: For exposure to an allergen (food, insect sting), if **SYMPTOMS** are in yellow boxes below OR if **2 or more AREAS** are affected, **GIVE EPINEPHRINE**!!!

AREAS	SYMPTOMS		circle
Throat	Tightening of throat, hoarseness, hacking cough	**Give Epinephrine**	Then Benadryl Zyrtec Inhaler
Lung	Shortness of breath, repetitive coughing, wheezing	**Give Epinephrine**	Then Benadryl Zyrtec Inhaler
Heart	Passing out, fainting, pale, blue or grey lips or skin	**Give Epinephrine**	Then Benadryl Zyrtec Inhaler
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		Give Benadryl Zyrtec Inhaler
Skin	Hives, swelling on face or extremities, itchy rash		Give Benadryl Zyrtec Inhaler
Gut	Nausea, abdominal cramps, vomiting, diarrhea		Give Benadryl Zyrtec Inhaler
General	Panic, sudden fatigue, chills, fear of impending doom		Give Benadryl Zyrtec Inhaler

Steps to Take:

* **Administer epinephrine**, followed by Benadryl/Zyrtec/Inhaler if prescribed. **Note** time administered.
* Instruct another person to **CALL 911**! Inform dispatch that the student is having a SEVERE allergic reaction and epinephrine has been administered.
* **DO NOT hesitate to administer medication or call 911.**
* Lay person down with legs elevated. Person can remain sitting if breathing is difficult. **Do not stand**.
* Stay with student until EMS arrives. Do not give student anything to eat or drink.
* **If 5 minutes have passed** and symptoms have not subsided or symptoms return, give another dose of epinephrine.

IMPORTANT REMINDER - If child is unable to self-treat, an adult must give medicine.

***The Anaphylaxis Emergency Plan with included Medication Prescription Information and Licensed Independent Provider and Parent/Guardian Signatures requires review or renewal annually.

Student Name ______________________________

Emergency Medication:	Student's approximate weight: ________lbs or ________kg

1. **Epinephrine Brand Name**: ____

☐ Epinephrine Auto Injector 0.15mg (patients who weigh 15 to 30 kg /33 – 66 pounds), IM

☐ Epinephrine Auto Injector 0.30mg (patients who weigh over 30 kg /66 pounds), IM

☐ Other dose/route (ie. Nasal): Dose ____________ Route _____________

For intramuscular injections, **inject into upper outer thigh & hold for 3-10 seconds**

Purpose of Medication: Anaphylaxis Treatment

Possible Side Effects: increased heart rate, pale skin, tremor

Disposition of Student after Medication Administration: **Call 911, medical observation required.**

2. **Antihistamine**, by mouth: **Name** ______________________________ **Dose** __________

Purpose of Medication: Allergic Reaction Treatment

Possible Side Effects: ____

Disposition of Student after Medication Administration: ______________________________

3. **Other** (ie. Inhaler): **Name** ______________________________ **Dose** ____________

Route:______________ Purpose of Medication: ______________________________

Possible Side Effects: ____

Disposition of Student after Medication Administration: ______________________________

TO BE COMPLETED BY PARENT/GUARDIAN:

As Parent/Guardian of the named student:

* I agree to indemnify, defend, and hold the School District harmless from any and all claims, actions, cost, expenses, damages, and liabilities, including attorney's fees, arising out of, connected with, or resulting from the administration of medication.
* I agree that the School District, Board of Education, Board of Education Employees and its Agents shall incur no liability as a result of any injury arising out of or connected with the administration of medication.
* I agree I will not institute either on our own behalf or behalf of the pupil, any claim or action against the Board of Education, Board of Education employees and its agents arising out of or connected with administration of medication.
* I understand this agreement must be signed and in full effect prior to the administration of medication.
* My child and I understand there are serious consequences for sharing any medication with others.
* I understand School Authorities will notify Parent/Guardian at the end of the school year to pick up medication. Medication which is not repossessed by the Parent/Guardian within a seven-day period of notification by school authorities will be destroyed by the District Nurse in the presence of a witness.
* I understand I am responsible to notify the District Nurse of any change in my child's health status, care, or medication order.

______________________________ (   ) ______________________

Parent/Guardian Name (please print) Best Contact Phone Number

______________________________ ______________________

Parent/Guardian Signature **Date**

TO BE COMPLETED BY PARENT/GUARDIAN – Authorization for Exchange of Confidential Student Information

I authorize my child's **Health Care Provider** (name) ______________________________to exchange confidential health information with the District Nurse for the completion of this plan of care and to exchange health information and records for not more than 12 months after signature date.

Parent/Guardian Signature ______________________________ **Date** ______________________

By signing authorization, I understand that the parties named above are permitted to exchange written and verbal information regarding my child. The parties may also accept a photocopy of this release form and give it the same full force and effect as the original. I further understand that I may revoke this authorization in writing at any time by providing a copy of my revocation to the parties named above. The information used or disclosed under this release might be disclosed by the school district as an educational record, pursuant to FERPA and might no longer be protected by HIPAA.

TO BE COMPLETED BY PHYSICIAN - Student Independence Level

I confirm the student has a diagnosis of **Anaphylaxis/Severe Allergy,** and per my assessment:

❒ This student has been instructed in the proper way to administer rescue medications and is capable of self-carrying and self-administering these medications.

❒ This student requires a trained adult to administer rescue medications.

______________________________ (   ) ______________________

Licensed Independent Provider (LIP) Name (please print) Phone Number

______________________________ ______________________

LIP Signature **Date**