Anaphylaxis Individual Emergency Care Plan - Pemberton Township Schools

Name:_____DOB:_____

Allergy to:_____

Weight:_____lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

Does student have a documented incident of anaphylaxis? ☐ Yes ☐ No

Extremely reactive to the following:_____

Therefore:

☐ Give epinephrine immediately for **ANY** symptoms if there was a likely exposure

☐ Give epinephrine immediately if there was exposure to the allergen, **even if no symptoms are noted**

Otherwise:

Any SEVERE SYMPTOMS after suspected or known exposure:

One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, crampy pain

⇨

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box on back page)
4. Give additional medications *
   (If ordered)
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

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*Antihistamine & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis).
USE EPINEPHRINE

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hive around mouth/face, mild itch
GUT: Mild Nausea/discomfort

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1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professional and parent
3. Dismiss student to care of parent or Guardian
4. If symptoms progress (see above), USE EPINEPHRINE

Medication/Doses:

Epinephrine: ☐ 0.15mg or ☐ 0.3mg ☐ May repeat dose in 15 minutes if symptoms continue.

Antihistamine:_____

Other (e.g., inhaler-bronchodilator if asthmatic):_____

*By NJ state law the administration of epinephrine can be delegated to non-nursing school staff. Administration of antihistamine cannot be delegated.

Self-Administration:

☐ I have instructed the above student in the proper administration of epinephrine. It is my opinion that he/she is capable of self-administration. Student must notify the teacher or School Nurse when he/she has administered epinephrine.

OR

☐ It is my opinion that the above student **is not** capable of self-administration of epinephrine.

Contacts: Doctor:_____ Phone:_____

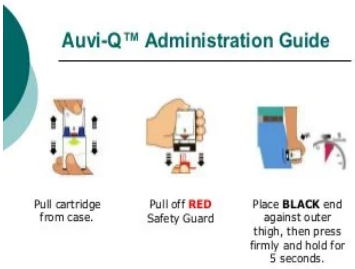
Parent/Guardian:_____ Phone:_____

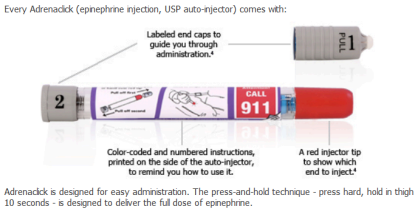
Other Emergency Contact:_____ Phone:_____

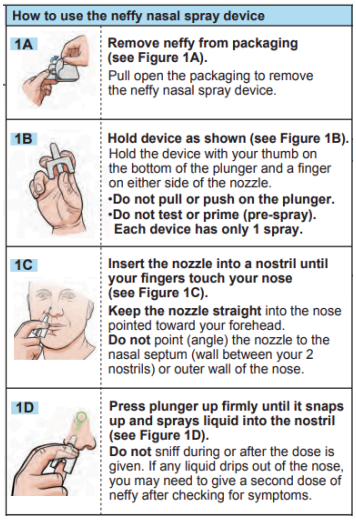
_____ _____
Parent/Guardian Signature Date

_____ _____
Healthcare Provider Signature Date

Dr.'s Office Stamp







Symjepi
-Remove needle cap
-Inject into middle of outer thigh, needle tip down
-Push plunger down until it clicks and hold for 2 secs
-Remove the needle and massage the area for 10 secs
-Pull the guard down until it clicks into place, put in case, dispose

A food allergy response kit should contain at least 2 doses of epinephrine, other medications as noted by the student's doctor, and a copy of this anaphylaxis care plan. A kit must accompany the student if he/she is off school grounds. (i.e., field trip).
Monitoring - Stay with the student; alert healthcare professionals & parents. Note the time when epi-pen was administered and tell EMS. Give used epi-pen to EMS for disposal. For a severe reaction, keep the student lying on back with legs raised. Treat student even if parents cannot be reached. See above auto-injection techniques.Once epi-pen is administered the student must be transported to a hospital by EMS.

Parent Authorization

I hereby give permission for my child to receive medication at school as prescribed in the Anaphylaxis Emergency Care Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In accordance with state law 18A:40-12.5, I give permission for the school nurse to delegate the administration of epinephrine to my child when the school nurse is not immediately available. A copy of this plan will be shared with the delegate(s)/appropriate school personnel. I understand that the district and its employees or agents shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector mechanism; and shall indemnify and hold harmless the district and its employees or agents against any claims arising out of administration of the epinephrine via a pre-filled auto-injector mechanism.

_____ _____
Parent/Guardian Signature Date

Fill out the section below only if your healthcare provider checked permission for your child to self-administer medication on the front of this form*. Recommendations are effective for the school year and must be renewed* ***annually.***

☐ I **do request** that my child be allowed to carry and self-administer medication per NJ state law in school pursuant to N.J.A.C:.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Anaphylaxis Emergency Care Plan for the current school year. I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents, and its employees shall incur no liability as stated above and for any injury arising from the self-administration by the student of the medication prescribed on this form.

☐ I **DO NOT** request that my child self-administer his/her anaphylaxis medication.

_____ _____
Parent/Guardian Signature Date