Life-Threatening Allergy Management Plan

Valid for Current School Year ______________

Name: ____________________________________ DOB: ____________________
Allergy to: ____

Asthma: ☐Yes* ☐No *High risk for severe reaction ☐yes ☐ no ☐ Asthma Action Plan

It is medically necessary for student to carry epinephrine during school hours ☐Yes ☐No

Signs of an Allergic Reaction Include:

Systems:	Symptoms:
MOUTH	Itching and swelling of the lips tongue or mouth
THROAT	Itching and or a sense of tightness in the 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 cough and/or wheezing
HEART	"thready pulse", "passing-out"

the severity of symptoms can quickly change. All the above symptoms can potentially progress to a life-threatening situation

Action for a Minor Reaction:

1. If ingestion is suspected and/or symptom(s) are: *minor itching "and/or" mild hives to skin give*:

Liquid Benadryl (or generic dephenhydramine) **Dose:_______________________**

by mouth now and every 4-6 hours as needed.

2. Call Mother at ______________________ Father at _________________ or emergency contact.
3. Call Dr. _____________ at ____________________ to make physician aware of child's reaction.

If condition worsens or does not improve within 10 minutes follow steps for MAJOR Reaction below:

Action for a Major Reaction:

1. If symptom(s) are large amount of hives, throat swelling, cough, difficulty breathing, wheezing, vomiting, diarrhea or if symptoms progress after Benadryl is given, give:

☐ **-Epinephrine: inject intramuscularly:** (check below)

☐ Epipen® ☐ Epipen® Jr ☐ Twinject ™ 0.3mg ☐ Twinject ™ 0.15mg

☐**-Liquid Benadryl**: dose: ____________ every 4-6 hours as needed (if able to tolerate liquids)

☐ **-Albuterol /or quick relief inhaler:** 2 puffs with spacer now (IF asthmatic)

Give above now then call:

2. **Call RESCUE SQUAD 911 ASK FOR <u>ADVANCED LIFE SUPPORT</u>**
3. **Repeat dose of Epinephrine if no improvement in 5-10 minutes**
4. Call Mother at ______________________ Father at _________________ or emergency contact.
5. Call Dr. _____________ at _______________ to make physician aware of child's reaction.

_________________________ __________ _________________________ __________

PARENTS SIGNATURE **DATE** **DOCTOR'S SIGNATURE** **DATE**:

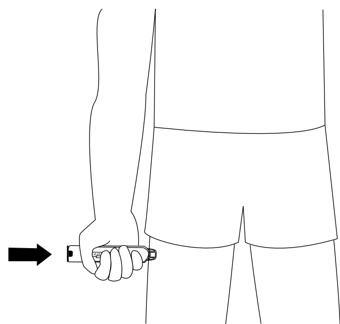
Print MD Name: ______________________________

6/10 **Address:** ______________________________

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- **First, remove the EPIPEN Auto-Injector from the plastic carrying case**
- **Pull off the blue safety release cap**

- **Hold orange tip near outer thigh (always apply to thigh)**

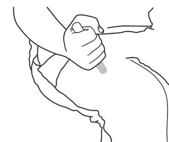


- **Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds**

DEY™ and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

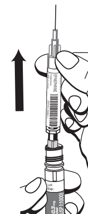
Twinject® 0.3 mg and Twinject® 0.15 mg Directions

- **Remove caps labeled "1" and "2."**
- **Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.**

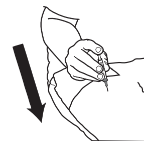


<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:

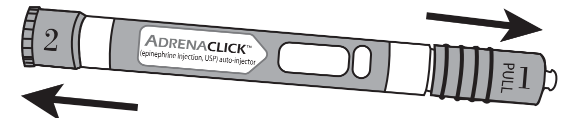
- **Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.**



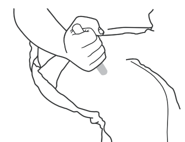
- **Slide yellow collar off plunger.**
- **Put needle into thigh through skin, push plunger down all the way, and remove.**



Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



- **Remove GREY caps labeled "1" and "2."**
- **Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.**



Once epinephrine is used, call the Rescue Squad and request an ambulance equipped with epinephrine and a responder trained to administer this medication. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

Feb. 2010

Life-Threatening Allergy Management Plan (LAMP)

Permission to Carry and/or Self-Administer Epinephrine (if appropriate)

Name: ________________________________ DOB: _________________________

I, as the Healthcare Provider, certify that this child has a medical history of severe allergic reactions has been trained in the use of the prescribed medication(s) and is judged to be capable of carrying and self-administering this medication(s). The nurse or the appropriate school staff should be notified anytime the medication/injector is used. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice.

☐ Self-Carry

☐ Self-Administer

____________________________	____________________________	__________
Healthcare Provider Signature	Print Healthcare Provider name	Date

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In accordance with the Code of Virginia Section 22.1-274, I agree to the following:

I will not hold the school board or any of its employees liable for any negative outcome resulting from the self-administration of said emergency medication by the student.

I understand that the school, after consultation with the parent(s) may impose reasonable limitations or restrictions upon a student's possession and/or self-administration of said emergency medication relative to the age and maturity of the student or other relevant consideration.

I understand that the school may withdraw permission to possess and self-administer the said emergency medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that the student is not safely and effectively self-administering the medication.

________________________________	________________________________
Parent/Guardian Signature	Date
________________________________	________________________________
Student Signature	Date