MAPLE SHADE PUBLIC SCHOOLS
Health Office

Place Child's Picture Here

ANAPHYLAXIS INDIVIDUAL EMERGENCY CARE PLAN

Student's Name: _____ DOB: _____ Teacher: _____

ALLERGY TO: _____

Asthmatic: **Yes*** ☐ **No** ☐ *** Higher Risk for Severe Reaction**

Parent/Guardian Telephone Numbers:

Name/Relationship	Home Phone	Work Phone	Cell Phone
_____	_____	_____	_____
_____	_____	_____	_____

TO BE COMPLETED BY PHYSICIAN'S OFFICE

This reaction **could** ☐ **could not** ☐ be described as anaphylactic. Symptoms, which he/she presented, include:

Please check off the appropriate symptoms

- ☐ Skin: "hives" (red blotches or welts which itch); severe swelling
- ☐ Eyes: tearing, redness, itching
- ☐ Lungs: shortness of breath, rapid breathing, cough, wheeze
- ☐ Gut: repeated vomiting, nausea, abdominal pain (diarrhea later)
- ☐ Brain: anxiety, agitation, or loss of consciousness
- ☐ Throat: tightness, trouble speaking, and trouble breathing
- ☐ Nose: running, itching, congested
- ☐ Mouth: itching, swelling of lips, tongue, or mouth
- ☐ Heart/Circulation: weak pulse, loss of consciousness

In the event of an allergic reaction, the school nurse should proceed as follows:

1. If the child develops only hives (only skin problems) give antihistamine.
   a. Dose: **Benadryl** _____ mg by mouth
      Oral antihistamine must be given only by nurse or parent.
   b. Observe closely for additional symptoms for the next six hours; notify parent/guardian
2. If the child develops any of the signs of severe reaction of anaphylaxis, **immediately**
   a. Inject **Epinephrine** IM: Dose ☐ .15mg ☐ .30mg
   b. This dose of IM Epinephrine may be repeated in 15 minutes if symptoms recur.
   c. Give the above dose of Benadryl by mouth
   d. Notify parent/guardian, and call 911
3. If wheezing occurs, treat with: _____

In the event of an allergic reaction when the school nurse is unavailable (field trip, after school activities, or athletics):

☐ **Able to self-medicate**

I give my permission for this child to self-medicate when the school nurse is not available. This student is allowed to administer a pre-measured dose of an antihistamine simultaneously with the Epi-Pen only for anaphylaxis. I give permission for a trained delegate to administer an Epi-Pen in the event this child is unable to do so.

☐ **Unable to self-medicate**

This child is not able to self-medicate at this time. In the event of an anaphylactic reaction when the nurse is not available, I give my permission for a **trained delegate** to administer a single dose of an Epi-Pen, and call 911.

I understand that the delegate is not permitted by NJ State law to give benadryl.

_____ _____

Physician's Signature **Date** **Office Stamp**

As the parent/guardian, I shall indemnify and hold harmless the district and its employees for any injury arising from the administration of a single, pre-filled, auto injector of epinephrine to my child. I agree with the plan as developed by my child's physician, and will provide the prescribed medications.

_____ _____

Parent Signature **Date**

I would ☐ **would not** ☐ **like my child to sit at a peanut free lunch table.**