Penn Manor School District
Allergy Emergency Care Plan

Nurse's Office Direct Fax Number: 1-888-510-8011

Name: _____ DOB:_____ Grade: ____ School: _____

Allergy to: (check appropriate - To be completed by Health Care Provider)

- □ Foods (list): _____
- □ Stinging Insects (list): _____
- □ Latex: Circle: Type I (anaphylaxis) Type IV (contact dermatitis)
- □ Medications (list): _____
- □ Other (list): _____

Asthma: ☐ **YES** (higher risk for a severe reaction**)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

[ ] If checked, give epinephrine immediately for **ANY** symptoms if ingested or exposed to the allergen.
[ ] If checked, give epinephrine immediately if ingested or exposed to the allergen, **EVEN IF NO** symptoms are noted.
[ ] If checked, observe for 20 minutes if ingested or exposed to the allergen and **NO** symptoms noted.

For **ANY** of the following **SEVERE SYMPTOMS:**

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **CALL 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive
3. Consider giving additional medications following epinephrine: Antihistamine and/or Inhaler (bronchodilator) if wheezing.
4. Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
5. If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
6. Alert emergency contacts.
7. Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

For **ANY** of the following **MILD** SYMPTOMS:

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

_____

For **MILD SYMPTOMS** from a **SINGLE SYSTEM** area, follow the directions below:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.
4. For **MILD SYMPTOMS** from **MORE THAN ONE** system area, give Epinephrine.

_____

MEDICATIONS/DOSES

Epinephrine Brand: _____
Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand/Generic: _____
Antihistamine Dose: _____

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

TURN OVER TO COMPLETE THE BACK. SIGNATURES REQUIRED ON THE BACK

SELF CARRY

☐ This student has received instruction in the proper use of the auto-injector. It is my professional opinion that this student **SHOULD** be allowed to carry and use the auto-injector independently. The student knows when to request antihistamine and has been advised to inform a responsible adult if the auto-injector is self-administered.

School Nurse

☐ The student has demonstrated the skills to carry and self-administer their auto-injector, including the necessity of informing an adult if auto-injector is used. Student has received instruction from the student's licensed physician, CRNP, or PA, on proper safety precautions for the handling and disposal of the auto-injector including acknowledgement that the student will not allow other students to have access to the prescribed medication and that he/she understands appropriate safeguards.

CSN Name _____ CSN Signature _____ Date_____

Student Name _____ Student Signature_____ Date _____

EMERGENCY CONTACTS - CALL 911 FIRST

1. Parent/Guardian: _____ Phone: _____

2. Parent/Guardian: _____ Phone: _____

Other Emergency Contacts:

3. Name/Relationship: _____ Phone: _____

4. Name/Relationship: _____ Phone: _____

SIGNATURES

Healthcare Provider

Name _____ Signature _____ Date_____ Phone (___) _____-_____

Parent/Guardian

Name _____ Signature _____ Date_____ Phone (___) _____-_____

Signing verifies that you, the parent/guardian, give permission for the school staff to carry out the administration of the above prescribed plan in your absence, acknowledges that the school is not responsible for ensuring the medication is taken, and relieves the Board and its employees of responsibility for the benefits or consequences of such medication and its administration. I give permission to the doctor, school nurse, and other health care providers to share information about my child's allergy to help improve the health of my child.