

Life-Threatening Allergy Management Plan

To be completed by MD: Valid for Current School Year _____

Name: _____ DOB: _____ Weight _____

Allergy to: _____

Asthma: Yes (high risk for severe reaction) No See Asthma Action Plan

Extremely Reactive to: _____

If known exposure, give epinephrine immediately and call 911.

Action for Mild Reaction:

Systems:

Mouth:

Skin:

Gut:

Symptoms:

itchy mouth

minor itching "and/or" a few hives

mild nausea/discomfort



Liquid

diphenhydramine (12.5mg/5ml) p.o.

(can be repeated q 4-6 hours)

cetirizine (5mg/5ml) p.o.

(do not repeat)

Dose: _____

Stay with student. Alert parent. If symptoms worsen then follow steps for major reaction.

Action for a Major Reaction: (two systems or single severe symptom)

Systems:

MOUTH

THROAT

LUNG

HEART

SKIN

GUT

Symptoms:

swelling of the lips, tongue, or mouth

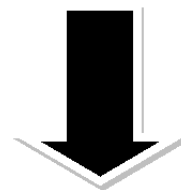
tight throat, hoarseness, drooling, trouble swallowing

shortness of breath, repetitive cough and/or wheezing

thready pulse, faint, confused, dizzy, pale, blue

multiple hives, swelling about the face and neck

abdominal cramps, vomiting



1. Inject Epinephrine immediately intramuscularly

Epipen® Epipen® Jr Auvi-Q™ 0.30mg Auvi-Q™ 0.15mg _____

2. Call RESCUE SQUAD 911 ASK FOR ADVANCED LIFE SUPPORT

- Students should not suddenly sit up, stand or be placed in the upright position. This increases risk for sudden death.

3. Note time epinephrine was given and repeat dose after 5 minutes if no improvement or worsening symptoms.

- Antihistamines and inhalers are not first line therapy in a severe reaction.

4. Transport via EMS to the emergency department.

Emergency Contacts:

Parent/Guardian _____ Phone: _____

Other emergency contact _____ Phone: _____

Parents Signature _____

DATE _____

DOCTOR'S SIGNATURE _____

DATE: _____

Nurses Signature _____

DATE _____

Print MD Name: _____

Contact number: _____

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

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