



ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN



Student Name:		Date of Birth:	Weight: lbs/kg
Date of Plan:	Age:	School of Attendance:	Grade:

Allergies:

- Child has asthma: yes no (if yes, higher chance of a severe reaction)
 Child has had anaphylaxis: yes no (if yes, higher chance of a severe reaction)
 Child may carry medicine: yes no
 Child may give him/herself medicine: yes no (if child unable, an adult must give medicine)

The **"Always-Epinephrine" Option**: If checked, give epinephrine immediately, if the child has **ANY** symptom (mild or severe) after a sting or eating a food listed above. (Option advised for those schools where a nurse is not always available)

**** IF IN DOUBT, GIVE EPINEPHRINE!** ANAPHYLAXIS is a potentially life-threatening, severe allergic reaction

<p>For SEVERE Allergy or Anaphylaxis What to look for: If child has ANY of these symptoms after eating a food or having a sting, give epinephrine</p> <ul style="list-style-type: none"> * <u>Breathing</u>: trouble breathing, wheeze, cough * <u>Throat</u>: tight or hoarse throat, trouble swallowing or speaking * <u>Brain</u>: confusion, agitation, dizziness, fainting, unresponsive * <u>Gut</u>: severe stomach pain, vomiting, diarrhea * <u>Mouth</u>: swelling of lips or tongue that affects breathing * <u>Skin</u>: face color is pale or blue, many hives or redness over body 	<p>Give EPINEPHRINE! What to do:</p> <ol style="list-style-type: none"> 1. Inject epinephrine right away! Note the time. 2. Call 9-1-1 <ul style="list-style-type: none"> ▪ Ask for ambulance with epinephrine ▪ Tell rescue squad when epinephrine was given 3. Stay with child and: <ul style="list-style-type: none"> ▪ Call parents ▪ Give a second dose of epinephrine if symptoms worsen or do not get better in 5 minutes. ▪ Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on their side 4. Give other medicine (e.g. antihistamine, inhaler) if prescribed. Do not use other medicine in place of epinephrine
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<p>For MILD Allergic Reaction. What to look for: If child has mild symptoms, or no symptoms but a sting or ingestion of the food is suspected, Give antihistamine and monitor the child. Mild symptoms may include:</p> <ul style="list-style-type: none"> * <u>Skin</u>: a few hives, mild rash, mild swelling OR * <u>Mouth/nose/eyes</u>: itching, rubbing, sneezing OR * <u>Gut</u>: mild stomach pain, nausea or discomfort <p>Note: if the child has more than one mild symptom area affected, give epinephrine</p>	<p>Give Antihistamine and Monitor the Child What to do:</p> <ol style="list-style-type: none"> 1. Give antihistamine if prescribed 2. If in doubt, give epinephrine 3. Call parents 4. Watch child closely for 4 hours 5. If symptoms worsen, give epinephrine (See "For SEVERE Allergy and Anaphylaxis")
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Medicine/Doses

- Epinephrine (intramuscular in thigh): 0.15 mg 0.30 mg
 Antihistamine (by mouth): Diphenhydramine ____ mg (____ml) Other _____: ____mg (____ml)
 Other medications: Albuterol 2-4 puffs other: _____

PROVIDER (electronic) Signature Date Name (Printed) Phone FAX

Allergy and Anaphylaxis Emergency Plan

Plan de emergencia para alergia y anafilaxia

Child's Name: _____ Date of Plan: _____
El nombre del niño *Fecha del plan*

Doctor name (print): _____ Office Phone: (____) _____ - _____
El nombre del doctor (imprimir) *telefono de oficina*

Office Address: _____ Office Fax: (____) _____ - _____
dirección de la oficina *oficina fax*

Emergency Contacts (*contactos de emergencia*):

Name/Relationship: _____ Phone: (____) _____ - _____
Nombre/relación *telefono*

Name/Relationship: _____ Phone: (____) _____ - _____
Nombre/relación *telefono*

CALIFORNIA ADMINISTRATIVE CODE, TITLE 5 SECTION 3051.12, provides that when a parent elects to perform or have non-district personnel perform a Specialized Physical Health Care Service in a school program, a waiver shall be signed by the parent relieving the school district from any and all responsibility related to delivery of such specialized service when non-district personnel provide this service. This waiver also applies to students who have been given responsibility to perform such services. This may include self-medication as prescribed.

WE (I) as parent(s) of student named above hereby elect to have the above specified health services or medications, performed/administered by ourselves, by the student him/herself, or by non-district personnel on the school site during regular school hours. Furthermore, in electing to provide such service, we (I) agree to hold Coronado Unified Schools and its employees free from any and all responsibility for such service or the manner in which it is administered.

Signature of Parent or Legal Guardian	Date Signed
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EL CÓDIGO ADMINISTRATIVO DE CALIFORNIA, SECCIÓN 5, ARTÍCULO 3051.12, indica que cuando el apdre/madre opta por realizar o por que el personal que no pertenezca al distrito realice dentro de un programa escolar un Servicio Especializado de Atención a Salud Física, el padre/madre debe firmar un formulario de exención para eximir al distrito escolar de cualquier responsabilidad relacionada a la ejecución de dicho servicio especializado cuando éste sea proporcionado por personal que no pertenece al distrito. Esta exención también aplica a los alumnos a quienes se les ha dado la responsabilidad de realizar tales servicios. Esto puede incluir auto suministro de medicinas como se les has recetado.

Nosotros (yo) como padre/madre del alumno/a arriba mencionado, por la presente elijo tener los servicios de salud arriba especificados o medicamentos, suministrados o aplicados por nosotros mismo, por el/la estudiante mismo/a o bien por un personal no perteneciente al distrito el la escuela durante el horario normal. Por consiguiente, al elegir el brindar tal servicio, nosotros (yo) estoy de acuerdo de liberar a Coronado Unified y a sus empleados de cualquier y toda responsabilidad port al service o de la manera como sel le suministra

Firma del Padre/Madre o Tutor	Fecha de firmado
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Additional Information/Instrucciones Adicionales:

Anaphylaxis Action Plan

Emergency Care Plan

School Year: _____ to _____

Student Name: _____ Date of Birth: _____

Anaphylaxis History: (to be filled out by Parent/Guardian)

Number of Allergic Reactions in the past: _____

When your child has had a Food Allergy Reaction in the past, describe what his/her reaction looked like:

How have your child's past reactions been treated? _____

Number of times an Epinephrine Pen has used: _____

Number of Visits to Emergency Room/Hospital for Allergic Episode: _____

Emergency Contact Information:

Parent/Guardian Name: _____

Signature: _____

Phone Number: _____

Alt. Phone Number: _____

Parent/Guardian Name: _____

Signature: _____

Phone Number: _____

Alt. Phone Number: _____

Alternate Emergency Contacts

Name/Relationship: _____

Phone Number: _____

Name/Relationship: _____

Phone Number: _____

Modified from FAAN Form 11/4/15

www.foodallergy.org

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