# ST. MARY'S SCHOOL
## ANAPHYLAXIS EMERGENCY CARE PLAN

Student's name:_____Grade/Teacher's name:_____

Known Allergies:_____

Does your child have asthma? Yes_____ No_____ (If yes, higher risk for severe reaction)

### Signs and Symptoms of Anaphylaxis:

| **Systems:** | **Symptoms:** |
|---|---|
| MOUTH | itching & swelling of the lips, tongue, or mouth |
| THROAT* | itching and/or a sense of tightness in throat, hoarseness, and hacking cough |
| SKIN | hives, itchy rash, and/or swelling around the face or extremities |
| GUT | nausea, abdominal cramps, vomiting, and/or diarrhea |
| LUNG* | shortness of breath, repetitive coughing, and/or wheezing |
| HEART* | "thready" pulse, "passing-out" |

***The symptoms of a reactions are not always consistent and could include any of the above.**
***The severity of symptoms can quickly change.**
***All above symptoms can potentially progress to a life-threatening situation!**

### Parent/Guardian/Emergency Contacts:

Call 1st: _____Cell:_____Other Daytime:_____

Call 2nd: _____Cell:_____Other Daytime:_____

Call 3rd: _____Cell:_____Other Daytime:_____

### Steps to Take During an Anaphylactic Event - Emergency Protocol

1. Remain calm. Reassure the student and do not leave them alone.
2. Notify the health office IMMEDIATELY and staff will bring the epinephrine.
3. **Inject epinephrine IMMEDIATELY** and note time when it was given.
4. **Call 911**. Request an ambulance and specify that the child is having an anaphylactic reaction; state your location in the school.
5. If a second student-specific EpiPen is available, give another dose within 15 minutes if symptoms return or worsen and emergency services have not yet arrived.
6. Alert parent/guardian(s).

**Physician's Authorization for Medication Administration**

| **Epinephrine Device** | **Dosage** | **Time** | **Special Instructions** |
|---|---|---|---|
| | | | |

**Self-Carry? Yes____ No____** *If yes, I understand this student will carry the above listed medication at school. I also understand this student will be entirely responsible for the use of this medication and use will not be monitored by school personnel.*

| **Other Pertinent Medication** | **Dosage** | **Time** | **Special Instructions** |
|---|---|---|---|
| | | | |

**Physician's Signature X**_____Date:_____

Physician (Printed Name)_____Phone:_____

**Please see reverse side of this form for Parent Authorization and Self Administration Procedure**

**OVER→**

## Anaphylaxis Emergency Care Plan Continued:

### Authorization For Staff Administration Of Medication Including when on Field Trips

I understand that trained school personnel will follow the Anaphylaxis Emergency Care Plan as completed by my child's physician, school nurse, and myself. Further, under the delegation of the LSN/RN, I hereby give my permission that trained school personnel can administer this emergency medication in the absence of a school nurse or if my child is away from the school on a field trip or other school activity during regular school hours. I release school personnel from any liability in relation to this request when the medication is given as ordered.

Parent/Guardian Signature_____Date:_____

### Authorization to Share Health Information with St. Mary's School SAC Program

❑ Not applicable

My child will be attending SAC on various days throughout the school year. I authorize that a copy of my child's Anaphylaxis Emergency Care Plan may be shared with the SAC program supervisor for collaboration and continuity of care during before and after school hours. ***PLEASE NOTE: PARENT MUST PROVIDE ADDITIONAL EPIPEN TO THE SAC SUPERVISOR.***

Parent/Guardian Signature_____Date:_____

### Self-Administration Of Medication - FOR THOSE 6TH GRADE AND OLDER

❑ Not applicable

I hereby authorize my child to self-administer the above named medication(s) during school as prescribed by the physician. I have read the student agreement below. I understand that my child will carry this medication at school and use will not be monitored by school personnel. I understand that trained school personnel will follow the Anaphylaxis Emergency Care Plan as completed by my child's physician, school nurse, and myself should my child be unable to self-administer his/her medication.

Parent/Guardian Signature:_____Date:_____

### Student Agreement for Self-Administration of Medication

❑ Not applicable

I agree to:

- ❑ Follow my prescribing physician medication orders.
- ❑ Use correct medication administration technique.
- ❑ Not allow anyone else to use my medication.
- ❑ Keep a supply of my medication with me in school and on field trips.
- ❑ Notify the school nurse or health office personnel if my epinephrine is administered and 911 will be called.
- ❑ Notify the school nurse or health office personnel if I have any exposure to allergy-causing food or substances or exhibit any symptoms of an allergic reaction.

Student Signature:_____Date:_____

**The student has demonstrated knowledge about proper use of his/her medication (epinephrine) administration.

LSN/RN Signature:_____Date:_____

**This Anaphylaxis Emergency Care Plan has been reviewed.**

LSN/RN Signature:_____Date:_____