Springboro Community City Schools Health Services

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Attach child's photo

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____**Weight:** _____**School/Grade/:** _____**BUS #**_____

Child has allergy to _____

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may SELF carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents or emergency contact.
   - Give a second dose of epinephrine, if symptoms get worse, continue, 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 his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents or emergency contact.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): _____

☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): _____ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____

Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

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Child's name: _____ **Date of plan:** _____

Additional Instructions: Pg 2 to be Completed by the Parent and Clinic Nurse

I have read and understand Springboro Community City Schools Medication Policy. I give my permission for information to be sent to the school district via facsimile.

I, hereby, authorize designated personnel of the Springboro Community City School District to administer the above named medication or procedure as instructed by the physician, and agree to:

1. **Provide the school with the medication in the container in which it was dispensed by the prescribing physician or licensed pharmacist.**
2. **Notify the school if we change physicians.**
3. **Notify the school if the medication, dosage, or procedures is changed or is to be eliminated.**
4. **Release authorized school employees from all liability, cause of action, or any other responsibility for administering said medicines as noted above.**

Parent Signature: _____ **Clinic Nurse Signature:** _____
Date:_____
Completed by Clinic Staff at Medication Check-In/Processing:
Medication/Dosage: _____ **Med Expiration Date:** _____
Medication/Dosage: _____ **Med Expiration Date:** _____
Medication/Dosage: _____ **Med Expiration Date:** _____
DASL Entry: _____ **Health Concern List:** _____ **EAP Copies Made/Distributed:** _____/_____
Medication Sign Out: _____/_____ **Date:**_____

School Activity Participation (*Grades 7-12) BAND JROTC Athletics _____ **Form Revision 5/2024**

Contacts

Clinic Nurse Name/ Phone #: _____

Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contacts

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

