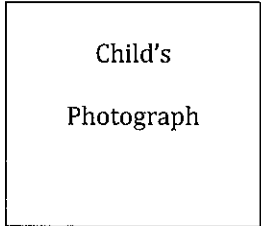


# EMERGENCY ACTION PLAN

SCHOOL YEAR: 2011-2012



NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_

TEACHER: \_\_\_\_\_ GRADE: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

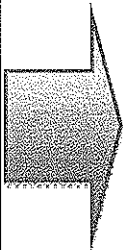
Asthma:  Yes (higher risk for severe reaction)  No      Weight: \_\_\_\_\_ lbs

## SECTION 1. EMERGENCY PROCEDURES

**IF STUDENT HAS ANY SEVERE SYMPTOMS AFTER SUSPECTED EXPOSURE TO ALLERGEN:**  
LUNG: Short of breath, wheeze, repetitive cough  
HEART: Pale, blue, faint, weak pulse, trouble breathing/swallowing  
SKIN: Many hives over body

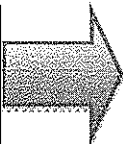
Or Combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling  
GUT: Vomiting, crampy pain



1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring the child (see below)
4. Give additional medications: Antihistamine, Inhaler (bronchodilator) if asthma

**IF STUDENT HAS MILD SYMPTOMS ONLY**  
MOUTH: Itchy mouth  
SKIN: A few hives around mouth/face, mild itching  
GUT: Mild nausea/discomfort



1. **GIVE ANTIHISTAMINE**
2. Stay with and continue monitoring the child
3. Alert health care professionals
4. Contact Parent
5. **IF SYMPTOMS PROGRESS AT ANY TIME TO SEVERE (see above) INJECT EPINEPHRINE**

**MONITORING THE STUDENT:**

1. Stay with the child
2. Do not depend on inhaler/bronchodilators and antihistamines to treat a severe allergic reaction (anaphylaxis), Inject Epinephrine
3. When in doubt, use epinephrine. Symptoms can rapidly become more severe.
4. For severe symptoms, treat the child even if parents cannot be reached.
5. For a severe reaction, consider keeping the child lying on back with legs raised.
6. A second dose of epinephrine may be given, as prescribed by the student's health care provider, after the first injection if symptoms persist or recur.
7. Tell paramedics the amount of epinephrine given to the child.

**SECTION 2. SCHOOL ADMINISTRATION OF MEDICATION**  
**PRIMARY LOCATION OF MEDICATION    BACKUP LOCATION OF MEDICATION**

Student to carry

School Nurse/Health office

Other

School Nurse/Health office

Principal/Main office

Other

**TRAINED VOLUNTEER STAFF MEMBERS:**

Name: \_\_\_\_\_

Room: \_\_\_\_\_

Name: \_\_\_\_\_

Room: \_\_\_\_\_

Name: \_\_\_\_\_

Room: \_\_\_\_\_

**SECTION 3. MEDICATION AUTHORIZATION**

*Must be completed by the student's physician, physician assistant, or advanced practice registered nurse*

If checked, give epinephrine for ANY symptoms if the child was likely exposed to the allergen

If checked, give epinephrine BEFORE symptoms if the child was exposed to the allergen

**MEDICATIONS**

EPINEPHRINE AUTO-INJECTOR: Brand: \_\_\_\_\_ Dose: \_\_\_\_\_

Purpose: \_\_\_\_\_

Time(s)/Circumstances to be administered: \_\_\_\_\_

Time Interval for re-evaluation: \_\_\_\_\_

Child may Self-Administer     Yes                       No

ANTIHISTAMINE (brand and dose): \_\_\_\_\_

ASTHMA INHALER/BRONCHODILATOR (brand and dose): \_\_\_\_\_

OTHER MEDICATIONS (brand and dose): \_\_\_\_\_

Licensed Healthcare Provider Printed Name: \_\_\_\_\_

Licensed Healthcare Provider Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Licensed Healthcare Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## SECTION 4. PARENT/GUARDIAN AUTHORIZATION

*To be completed by the child's Parent/Guardian*

### Emergency Contact Information:

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including administration of medication to my child. I understand that the Local Government and Governmental Employees Tort Immunity Act protects staff members from liability arising from actions consistent with this plan. I also hereby authorize the school district staff members to disclose my child's health-related student record information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of the plan.

### Self-Administration by Student

I hereby acknowledge that the School District, its officials, employees, and agents will incur no liability, except for willful and wonton conduct, as a result of any injury arising from the self-administration of medication or use of an epinephrine auto-injector by my child regardless of whether authorization was given by me or by my child's physician, physician's assistant, or advanced practice registered nurse. I hereby agree to indemnify and hold harmless the School District, its officials, employees, and agents, against any claims, except a claim based on willful and wonton conduct arising out of the self-administration of medication or use of an epinephrine auto-injector by my child regardless of whether authorization was given by me or by my child's physician, physician's assistant, or advanced practice registered nurse.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## SECTION 5. INCIDENT DOCUMENTATION

1. Gather and record information about the incident, including:
    - The child's allergic reaction
    - The individuals who administered medication or otherwise assisted in the medical intervention,
    - The staff members, students, or other individuals who witnessed the event
  2. Save food eaten by the child before the allergic reaction, place in a plastic zipper bag (e.g. Ziploc bag) and freeze the contents for analysis.
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