

MAPLE SHADE PUBLIC SCHOOLS  
Health Office



**ANAPHYLAXIS INDIVIDUAL EMERGENCY CARE PLAN**

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Teacher: \_\_\_\_\_

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

**Asthmatic:** Yes\*  No  \* Higher Risk for Severe Reaction

**Parent/Guardian Telephone Numbers:**

Name/Relationship	Home Phone	Work Phone	Cell Phone
_____	_____	_____	_____
_____	_____	_____	_____

**TO BE COMPLETED BY PHYSICIAN'S OFFICE**

This reaction could  could not  be described as anaphylactic. Symptoms, which he/she presented, include:

**Please check off the appropriate symptoms**

- Skin: "hives" (red blotches or welts which itch); severe swelling
- Eyes: tearing, redness, itching
- Lungs: shortness of breath, rapid breathing, cough, wheeze
- Gut: repeated vomiting, nausea, abdominal pain (diarrhea later)
- Brain: anxiety, agitation, or loss of consciousness
- Throat: tightness, trouble speaking, and trouble breathing
- Nose: running, itching, congested
- Mouth: itching, swelling of lips, tongue, or mouth
- Heart/Circulation: weak pulse, loss of consciousness

**In the event of an allergic reaction, the school nurse should proceed as follows:**

1. If the child develops only hives (only skin problems) give antihistamine.
  - a. Dose: **Benadryl** \_\_\_\_\_ mg by mouth  
**Oral antihistamine must be given only by nurse or parent.**
  - b. Observe closely for additional symptoms for the next six hours; notify parent/guardian
2. If the child develops any of the signs of severe reaction of anaphylaxis, **immediately**
  - a. Inject **Epinephrine** IM: Dose  .15mg  .30mg
  - b. This dose of IM Epinephrine may be repeated in 15 minutes if symptoms recur.
  - c. Give the above dose of Benadryl by mouth
  - d. Notify parent/guardian, and call 911
3. If wheezing occurs, treat with: \_\_\_\_\_

**In the event of an allergic reaction when the school nurse is unavailable (field trip, after school activities, or athletics):**

**Able to self-medicate**

I give my permission for this child to self-medicate when the school nurse is not available. This student is allowed to administer a pre-measured dose of an antihistamine simultaneously with the Epi-Pen only for anaphylaxis. I give permission for a trained delegate to administer an Epi-Pen in the event this child is unable to do so.

**Unable to self-medicate**

This child is not able to self-medicate at this time. In the event of an anaphylactic reaction when the nurse is not available, I give my permission for a **trained delegate** to administer a single dose of an Epi-Pen, and call 911.

**I understand that the delegate is not permitted by NJ State law to give benadryl.**

\_\_\_\_\_  
**Physician's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Office Stamp**

As the parent/guardian, I shall indemnify and hold harmless the district and its employees for any injury arising from the administration of a single, pre-filled, auto injector of epinephrine to my child. I agree with the plan as developed by my child's physician, and will provide the prescribed medications.

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Date**

I would  would not  like my child to sit at a peanut free lunch table.