

**Allergy and Anaphylaxis Emergency Plan  
Hanover Township School District**



Child's name: \_\_\_\_\_ Date of plan: \_\_\_\_\_

Date of birth: \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Weight: \_\_\_\_\_ kg

Child has allergy to \_\_\_\_\_

- Child has asthma.  Yes  No (If yes, higher chance severe reaction)
- Child has had anaphylaxis.  Yes  No
- Child may 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-threatening, 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.**

**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

**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 and child's doctor.
  - 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

**Monitor child**

**What to do**

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

**Medicines/Doses**

Epinephrine, intramuscular (list type): \_\_\_\_\_ Dose:  0.15 mg  0.30 mg (weight more than 25 kg)

Antihistamine, by mouth (type and dose): \_\_\_\_\_

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

**Please Note:** Since delegates cannot administer an antihistamine, in the absence of a school nurse or when on a field trip, a trained delegate will give epinephrine only and any antihistamine order will be disregarded

\_\_\_\_\_  
Parent/Guardian Authorization Signature Date Physician/HCP Authorization Signature Date

## Allergy and Anaphylaxis Emergency Plan

Child's name: \_\_\_\_\_ Date of plan: \_\_\_\_\_

Additional Instructions:

**Additional Instructions:**

### Contacts

Call 911 / Rescue squad: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

### Other Emergency Contacts

Name/Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

# HANOVER TOWNSHIP PUBLIC SCHOOLS

## Emergency Administration of Epinephrine

### PARENTS' /GUARDIANS' AUTHORIZATION

<u>Pupil's Name</u>	<u>Date of Birth</u>	<u>Grade</u>
<u>Allergic Condition</u>		

#### Parents'/Guardians' Statement

1. In the event that our child, named above, experiences potentially life-threatening symptoms related to his/her allergic condition as described by his/her physician, we authorize the emergency administration of epinephrine by a pre-filled auto-injector by the school nurse, and in her absence by a registered nurse, or an employee designated by the school nurse in consultation with the Hanover Township Board of Education who is properly trained in the administration of epinephrine auto-injection to our child.
2. We acknowledge our understanding that if the procedures for the emergency administration of epinephrine are followed, the Hanover Township Board of Education, collectively and individually, as well as its employees and agents, shall have no liability as a result of any injury arising from the administration of epinephrine to our child.
3. We indemnify and hold harmless the Hanover Township Board of Education, collectively and individually, as well as its employees and agents against any claims arising out of the emergency administration of epinephrine to our child.
4. We understand that our child will be transported to the hospital Emergency Room after the administration of epinephrine even if the child's symptoms have resolved.
5. We understand that the School Nurse will be available during school hours and may be available at school-sponsored events in case of an allergic reaction. The trained designee will be available during school hours and at school-sponsored events. We realize that it is our responsibility to inform the nurse in a timely manner of the school-sponsored events in which our child will participate.
6. Permission for the emergency administration of epinephrine to our child is granted for the \_\_\_\_\_ school year.
7. We agree to have \_\_\_\_\_ trained as the epinephrine designee and understand that the designee, by law, cannot administer any other medication
8. As Parent/Guardian of the above named student I hereby authorize the release of pertinent medial information to be exchanged among appropriate professional staff involved in the care of my child. This consent is valid for the school year and is intended to allow the staff to better serve my child.
9. I have read the Emergency Health Care Plan for my child and give my permission for its implementation.

\_\_\_\_\_  
Signature of Parent/Guardian/Date

\_\_\_\_\_  
Signature of Parent/Guardian/Date

HANOVER TOWNSHIP PUBLIC SCHOOLS  
Self Administration of Medication-Parent Release Form

TO: Parents/Guardians of Pupils  
FROM: Hanover Township Board of Education  
SUBJECT: **SELF-ADMINISTRATION OF EPINEPHRINE**

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The Hanover Township Board of Education hereby informs parents/guardians of pupils who have an emergency order for the self-administration of epinephrine that the Hanover Township School District and its employees or agents shall incur no liability as a result of any injury arising from the said self-administration of epinephrine by the pupil.

I, the undersigned, hereby acknowledge that I have read and understood the above statement,

I also acknowledge that the Hanover Township School District shall incur no liability as a result of any injury arising from the administration of epinephrine by my child, \_\_\_\_\_  
(full name of child)

I shall also hold harmless the Hanover Township School District and its employees or agents from any and all claims arising out of self-administration of medication by my child.

**Parents' Signature** \_\_\_\_\_

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