Life-Threatening Allergy Management Plan

To be completed by MD: Valid for Current School Year _____

Name: _____ DOB: _____Weight_____

Allergy to: _____

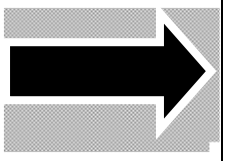
Asthma: □ Yes (high risk for severe reaction) □ No □ See Asthma Action Plan

Extremely Reactive to:_____

If known exposure, give epinephrine immediately and call 911.

Action for Mild Reaction:

Systems:	Symptoms:
Mouth:	itchy mouth
Skin:	minor itching "and/or" a few hives
Gut:	mild nausea/discomfort



Liquid

□ diphenhydramine (12.5mg//5ml) p.o. (can be repeated q 4-6 hours)

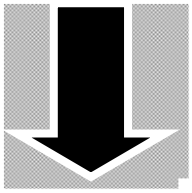
□ cetirizine (5mg/5ml) p.o. (do not repeat)

Dose:_____

Stay with student. Alert parent. If symptoms worsen then follow steps for major reaction.

Action for a Major Reaction: (two systems or single severe symptom)

Systems:	Symptoms:
MOUTH	swelling of the lips, tongue, or mouth
THROAT	tight throat, hoarseness, drooling, trouble swallowing
LUNG	shortness of breath, repetitive cough and/or wheezing
HEART	thready pulse, faint, confused, dizzy, pale, blue
SKIN	multiple hives, swelling about the face and neck GUT abdominal cramps, vomiting



1. Inject Epinephrine immediately intramuscularly
□ Epipen® □ Epipen® Jr □ Auvi-Q™ 0.30mg □ Auvi-Q™ 0.15mg □ _____

2. Call RESCUE SQUAD 911 ASK FOR ADVANCED LIFE SUPPORT
- **Students should not suddenly sit up, stand or be placed in the upright position. This increases risk for sudden death.**

3. Note time epinephrine was given and repeat dose after 5 minutes if no improvement or worsening symptoms.
- **Antihistamines and inhalers are not first line therapy in a severe reaction.**

4. Transport via EMS to the emergency department.

Emergency Contacts:

Parent/Guardian_____ Phone:_____

Other emergency contact_____Phone:_____

_____ _____ _____ _____

Parents Signature **DATE** **DOCTOR'S SIGNATURE**
DATE:

_____ _____ **Print MD Name: _____**

Nurses Signature **DATE** **Contact number**: _____

Life-Threatening Allergy Management Plan (LAMP)

Permission to Carry and/or Self-Administer Epinephrine (if appropriate)

Name: _____ DOB: _____

I, as the Healthcare Provider, certify that this child has a medical history of severe allergic reactions has been trained in the use of the prescribed medication(s) and is judged to be capable of carrying and selfadministering this medication(s). The nurse or the appropriate school staff should be notified anytime the medication/injector is used. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice.

☐ Self-Carry ☐ Self-Administer

_____ _____ _____

Healthcare Provider Signature Print Healthcare Provider name Date

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In accordance with the Code of Virginia Section 22.1-274, I agree to the following:

I will not hold the school board or any of its employees liable for any negative outcome resulting from the self-administration of said emergency medication by the student.

I understand that the school, after consultation with the parent(s) may impose reasonable limitations or restrictions upon a student's possession and/or self-administration of said emergency medication relative to the age and maturity of the student or other relevant consideration.

I understand that the school may withdraw permission to possess and self-administer the said emergency medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that the student is not safely and effectively self-administering the medication.

_____	_____
Parent/Guardian Signature	Date
_____	_____
Student Signature	Date

3/13