

**Johnson City Schools
Health Services
Severe Allergy Anaphylaxis Emergency Plan**

PARENT/GUARDIAN - Both pages must be completed

Name: _____ Date of Birth: _____ School Year: _____
School: _____ Grade: _____ Teacher/Homeroom: _____
Parent/Guardian: _____ Phone: _____ Email: _____
Address: _____ City/State/Zip: _____
Secondary Contact: _____ Phone: _____

Physician/Specialist Contact Information

Primary Care Provider: _____ Allergist (if applicable) _____
Phone: _____ Fax: _____ Phone: _____ Fax: _____

Medical Information

Student has allergy to: _____

Student has asthma: Yes No

Student has had anaphylaxis: Yes No

Has hospitalization been need in the past year for allergies? NO Yes (If yes) When? _____

Epinephrine will be kept in **Clinic** **Self-Carry**

If yes, location on person (backpack, pocket, etc): _____

Student must be competent to self-carry. Physician must approve student to self-carry.

Epinephrine must be in original box with prescription label.

****If Epinephrine is administered, emergency medical services and parents will be contacted.**

PARENT/GUARDIAN - Please Read and Sign on page 2 under Doctor's signature

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the healthcare provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Johnson City School System, the undersigned parent or guardian hereby understands and agrees that the Johnson City School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication. I, the undersigned parent or guardian hereby understand and agree that Johnson City Schools and its personnel shall not be liable for any injury resulting from the student's self-administration of the epinephrine, if applicable per health care provider's selection above, while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct. I will notify extra-curricular staff about the health plan and care to be given during after school activities, if applicable.

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Health Services
Severe Allergy Anaphylaxis Emergency Plan**

**HEALTHCARE PROVIDER - Please complete the information below and sign.
PERMISSION TO ADMINISTER MEDICATION**

Student has allergy to: _____

Epinephrine, intramuscular (list type): _____

Epinephrine Dose: 0.15 mg (33 lbs- 66 lbs) 0.3mg (66lbs or above)


































Antihistamine, by mouth (list type): _____

Antihistamine Dose: _____

Other (e.g., inhaler/bronchodilator if child has asthma): _____

Student has received instruction and has premission to self-carry epinephrine and use independently: Yes No

IMPORTANT REMINDER: Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, use epinephrine.

<p>For ANY of the following SEVERE SYMPTOMS OR A COMBINATION of symptoms from different body areas</p> <table style="width: 100%; text-align: center;"> <tr> <td> Shortness of breath, wheezing, or coughing</td> <td> Pale or bluish skin, weak pulse, fainting or dizziness</td> <td> Tight or hoarse throat, trouble breathing or swallowing</td> <td> Swelling of lips or tongue that bothers breathing</td> </tr> <tr> <td> Many hives of redness over body</td> <td> Feeling of "doom", confusion, altered consciousness or agitation</td> <td> Repetitive vomiting or severe diarrhea</td> <td></td> </tr> </table>	 Shortness of breath, wheezing, or coughing	 Pale or bluish skin, weak pulse, fainting or dizziness	 Tight or hoarse throat, trouble breathing or swallowing	 Swelling of lips or tongue that bothers breathing	 Many hives of redness over body	 Feeling of "doom", confusion, altered consciousness or agitation	 Repetitive vomiting or severe diarrhea		<p style="text-align: center; color: yellow;">MILD SYMPTOMS</p> <table style="width: 100%; text-align: center;"> <tr> <td> Itchy or runny nose, sneezing</td> <td> Itchy mouth</td> <td> Mild nausea or discomfort</td> <td> A few hives, mild itchy skin</td> </tr> </table> <p style="text-align: center;">MONITOR STUDENT Stay with student and watch him or her closely. Give Antihistamine (if listed above). Call Parents.</p> <p style="text-align: center; font-weight: bold;">If more than 1 symptom or severe allergy anaphylaxis symptoms develop, use epinephrine.</p>	 Itchy or runny nose, sneezing	 Itchy mouth	 Mild nausea or discomfort	 A few hives, mild itchy skin
 Shortness of breath, wheezing, or coughing	 Pale or bluish skin, weak pulse, fainting or dizziness	 Tight or hoarse throat, trouble breathing or swallowing	 Swelling of lips or tongue that bothers breathing										
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<p><input type="checkbox"/> SPECIAL SITUATION: If this box is checked, student has an extremely severe allergy to an insect sting, or the following food(s): _____</p> <p>Even if the child has MILD symptoms after a sting or eating allergen, give epinephrine.</p>													

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 Student.** Call parents. If symptoms get worse or continue after 5 minutes, give a second dose of epinephrine. Keep student lying on back. If the student vomits or has trouble breathing, keep child on his/her side.
4. **Give other medicine (if applicable) following epinephrine.** Antihistimine or Inhaler/bronchodilator if wheezing.

Healthcare Provider Name/Title	Healthcare Provider Signature	Date
Phone Number	Fax number	Email

By signing, parent indicates agreement with the individual health plan as described by healthcare provider.

Parent/Guardian Signature	Printed Name	Date
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Verified by School Nurse: Initial _____ Date _____ Reviewed with Clinic Nurse: Initial _____ Date _____
 Medical alert: Yes No