

# 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:

Mouth:

Skin:

Gut:

### Symptoms:

itchy mouth

minor itching "and/or" a few hives

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.**

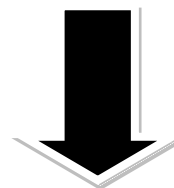
## Action for a Major Reaction: (two systems or single severe symptom)

### Systems:

MOUTH  
THROAT  
LUNG  
HEART  
SKIN  
GUT

### Symptoms:

swelling of the lips, tongue, or mouth  
tight throat, hoarseness, drooling, trouble swallowing  
shortness of breath, repetitive cough and/or wheezing  
thready pulse, faint, confused, dizzy, pale, blue  
multiple hives, swelling about the face and neck  
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 self-administering 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