

To be completed by provider: Valid for School Year _____

Name: _____ DOB: _____ Weight _____

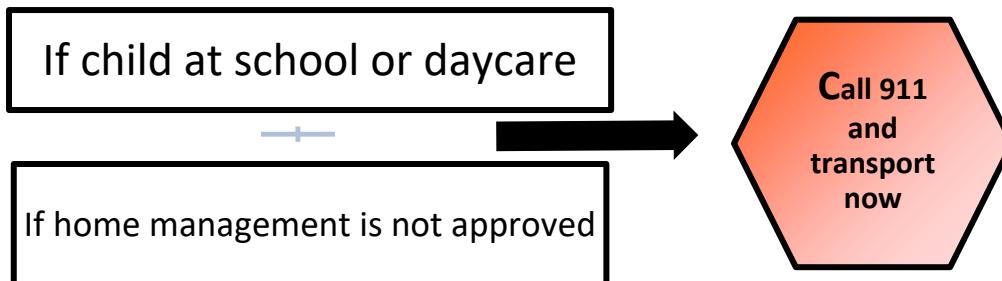
Allergy to: _____

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

Administer Epinephrine immediately (Can repeat after 5 minutes if no improvement):⊗ Epinephrine 0.3 mg IM (\geq 25 kg) ⊗ Epinephrine 0.15 mg IM (12 < 25kg)

⊗ Epinephrine 0.1 mg IM (<12 kg) ⊗ Epinephrine ___ mg INTRANASAL

**Action for Mild Reaction:****Systems: Symptoms:**

MOUTH	itchy mouth
SKIN	minor itching "and/or" a few hives
GUT	mild nausea

Liquid medication: cetirizine (5mg/5ml) p.o.

Dose: _____

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

Dose: _____

Stay with child. Alert parents. If symptoms worsen, then follow steps for major reaction.**Student may self-carry****Student may self-administer****Emergency Contacts:**

Parent/Guardian _____ Phone: _____

PARENT'S SIGNATURE

DATE

HEALTHCARE PROVIDER'S SIGNATURE

DATE

NURSE'S SIGNATURE

DATE

Print Healthcare Provider's Name: _____

Contact Number: _____

V. Life-Threatening Allergy Management Plan (LAMP)

Student:	School:	Effective Date:
Date of Birth:	Grade:	Homeroom Teacher:

Dear Parent/Guardian: Please provide the information requested below to help us care for your child at school.

Part 1 - Medical history and contact information. To be completed by parent/guardian.

Part 2 - Have your child's physician complete this section unless the physician's office prefers to use his/her own *Life Threatening Allergy Management Plan*, which must include all components.

Please note: A physician's order must be submitted to the school nurse at the beginning of each school year and whenever modifications are made to this plan.

Return completed forms to the school nurse as quickly as possible. Thank you for your cooperation.

Part 1 - To be completed by Parent/Guardian		
Contact Information:		
Parent/Guardian # 1:		
Address:		
Telephone - Home:	Work:	Cell:
Parent/Guardian # 2:		
Address:		
Telephone - Home:	Work:	Cell:
Other Emergency Contact:		Relationship:
Address:		
Telephone - Home:	Work:	Cell:
Physician treating severe allergy:		
Please answer the following question:		
1. What is your child allergic to?		
2. What age was your child when diagnosed?		
3. Has your child ever had a life-threatening reaction?		Yes No
4. What is your child's typical allergic reaction?		
5. Does your child have asthma?		Yes No

6. Does your child know what food/allergens to avoid?	Yes	No
7. Does your child recognize symptoms of his/her allergic reaction?	Yes	No
8. Will you be providing meals and snacks for your child at school?	Yes	No
9. Will your child always eat the school-provided breakfast and/or lunch?	Yes	No
10. How does your child travel to school?	Bus (Route # _____)	

I give permission to the school nurse and designated school personnel, who have been trained and are under the supervision of the school nurse of _____ School, to perform and carry out the severe allergy tasks as outlined in _____ (Child's name) *Life Threatening Allergy Management Plan (LAMP)* as ordered by the physician. I understand that I am to provide all supplies necessary for the treatment of my child's severe allergy at school. I also consent to the release of information contained in the LAMP to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also give permission to contact the above-named physician regarding my child's severe allergy.

Parent's Name	
Parent's Signature	Date
School Nurse's Name	
School Nurse's Signature	Date

**Every effort possible will be made to keep your child away from the stated allergen, however, this does not guarantee that your child will never come into contact with the stated allergen in the school setting.