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:		
Address:	Relationship:	
Telephone-Home:	Work:	Cell:
Physician treating severe allergy:		Office #:

Please answer the following questions:	
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 # _____ ☐ Car ☐ Walk	

Part 2: Life-Threatening Allergy Management Plan (LAMP)

To Be Completed By Health Care Provider **Valid for Current School Year _____**

Name: _____ DOB: _____

Allergy to: _____

Asthma: ☐Yes* ☐No *High risk for severe reaction ☐yes ☐ no ☐ Asthma Action Plan

It is medically necessary for student to carry epinephrine during school hours ☐Yes ☐No

Signs of an Allergic Reaction Include:

Systems:	**Symptoms:**
MOUTH	Itching and swelling of the lips tongue or mouth
THROAT	Itching and or a sense of tightness in the throat, hoarseness and hacking cough
SKIN	Hives, itchy rash and/or swelling about the face or extremities
GUT	Nausea, abdominal cramps, vomiting, and/or diarrhea
LUNG	Shortness of breath, repetitive cough and/or wheezing
HEART	"thready pulse", "passing-out"

the severity of symptoms can quickly change. All the above symptoms can potentially progress to a life-threatening situation

Action for a Minor Reaction:

1. If ingestion is suspected and/or symptom(s) are: *minor itching "and/or" mild hives to skin give*:

Liquid Benadryl (or generic dephenhydramine) **Dose:_____**

by mouth now and every 4-6 hours as needed.

2. Call Mother at _____ Father at _____ or emergency contact.
3. Call Dr. _____ at _____ to make physician aware of child's reaction.

If condition worsens or does not improve within 10 minutes follow steps for MAJOR Reaction below:

Action for a Major Reaction:

1. If symptom(s) are large amount of hives, throat swelling, cough, difficulty breathing, wheezing, vomiting, diarrhea or if symptoms progress after Benadryl is given, give:

☐ -**Epinephrine: inject intramuscularly:** (check below)

☐ Epipen® ☐ Epipen® Jr ☐ Twinject ™ 0.3mg ☐ Twinject ™ 0.15mg

☐**-Liquid Benadryl**: dose: _____ every 4-6 hours as needed (if able to tolerate liquids)

☐ **-Albuterol /or quick relief inhaler:** 2 puffs with spacer now (IF asthmatic)

Give above now then call:

2. **Call RESCUE SQUAD 911 ASK FOR ADVANCED LIFE SUPPORT**
3. **Repeat dose of Epinephrine if no improvement in 5-10 minutes**
4. Call Mother at _____ Father at _____ or emergency contact.
5. Call Dr. _____ at _____ to make physician aware of child's reaction.

_____ _____ _____ _____

PARENTS SIGNATURE **DATE** **DOCTOR'S SIGNATURE** **DATE**:

Print MD Name: _____

Address: _____

Part 3: 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

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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.