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		

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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.

Part 2: 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**: _____

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

Original August 2010
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