Maggie L. Walker Governor's School

Life-Threatening Allergy Management Plan (LAMP)

Student: _____ **Date of Birth:** _____ **Grade:** _____

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 clinic attendant at the beginning of each school year and whenever modifications are made to this plan.

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:		
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		

Return completed forms to Clinic (Room 102) as quickly as possible.

PART 2 – TO BE COMPLETED BY HEALTH CARE PROVIDER

Name: _____ **DOB:** _____ **School Year:** _____

Allergy to: _____

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

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
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	Thread 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 diphenhydramine) Dose _____ by mouth now and every 4-6 hours as needed.

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

Action for a Major Reaction:

1. If symptom(s) are large amounts 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 RESCUE SQUAD at 911 AND ASK FOR ADVANCED LIFE SUPPORT

2. **Repeat dose of epinephrine if no improvement in 5 – 10 minutes**
3. Call Mother at _____ Father at _____ or emergency contact at _____.
4. Call Dr. _____ at _____ to make physician aware of child's reaction.

_____ _____

Parent's Signature **Date**

_____ _____

Doctor's Signature **Print MD Name**

_____ _____

Address **Date**

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Clinic Attendant Permission Form

I give permission to the clinic attendant and designated school personnel, who have been trained and are under the supervision of the clinic attendant of Maggie L. Walker Governor's School, to perform and carry out the severe allergy tasks as outlined in _____ (Student) 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: _____ Date _____

Parent's Signature: _____

Clinic Attendant's Name: _____ Date _____

Clinic Attendant's Signature: _____

Life-Threatening Allergy Management Plan (LAMP)

Permission to Carry and/or Self-Administer epinephrine (if appropriate)

Name: _____ DOB: _____ Grade: _____

I, as the Healthcare Provider, certify that this child has a medical history of severe allergic reactions. He/she 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 clinic attendance or 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

In accordance with the Code of Virginia Section 22.1-274, I agree to the following:

I will not hold the Regional 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