Appendix D – Additional information & Emergency Action Plans for Anaphylaxis

Additional Information

If an adrenaline autoinjector is required to manage anaphylaxis is found to be out of date it can still be used. However, the emphasis is to ensure this does not happen.

If the adrenaline in the adrenaline autoinjector is discoloured please seek advice from emergency services before administration

Please complete the report form if adrenaline is administered for anaphylaxis / suspected anaphylaxis.

Emergency Action Plans - Anaphylaxis

There are now amended Emergency Action Plan forms for completion by the Consultant / GP.

1. These include Letter to parents
2. Report form
3. Type of Adrenaline Autoinjectors
4. EAP with Antihistamine
5. EAP signatures for Antihistamine
6. EAP with Epipen
7. EAP signatures for Epipen
8. EAP with Jext
9. EAP signatures for Jext
10. Additional page for additional volunteer signatures

All of these documents are posted and appear as separate documents on the EIS under ‘A’ on the EIS A – Z.

Dear Parent(s) or Carer,

Your child has an 'Emergency Action Plans' to enable the administration of an oral anti-allergy medicine (an antihistamine) if your child was to have a mild/moderate allergic reaction. In some cases you may also have an adrenaline autoinjector (EpiPen or Jext) to be used to manage a severe allergic reaction (anaphylaxis)

The emergency action plan has already been signed by the head teacher and volunteers that will have been trained and will administer the medication if required.

Please can you:

- Attach a passport sized photograph of your child.
- Sign the form yourself on the second page.
- Arrange for your child's doctor to complete and sign the remaining sections of the Emergency Action Plan:
    - If your child is looked after by the allergy service at the hospital please post your care plan to Kerrie Kirk, Children's Allergy Specialist Nurse, Ward 12, Leicester Royal Infirmary, LE1 5WW. The signed action plan will be posted back to you within two weeks.
    - If your child's allergy is looked after by your GP ask your GP to complete and sign the new action plan. Please give your GP surgery at least two weeks notice before you collect the new action plan.

Don't forget to:

- Check that your child's adrenaline autoinjectors have not gone out of date as they will not be as effective after this date.
- Make a note of the expiry dates as this is your responsibility even for the medication kept at school. If your child has a Jext® or an EpiPen® you can set up an expiry date alert to be sent to you by email or text – visit their website www.jext.co.uk or www.epipen.co.uk
- Ensure the new action plan is handed into the school on the first day of the new autumn term together with the medication required.
- Keep a copy of the 1st page of the form for yourself so that you also have a written action plan. This should be kept with the emergency medications at all times.

REPORT FORM

Following administration of adrenaline autoinjectors in response to anaphylaxis / suspected anaphylaxis

NAME OF CHILD: Date of birth:	Date of allergic reaction: ____/____/_____ Time reaction started: ____:____ hrs Time 1st dose adrenalin given: ____:____ hrs Time 2nd dose adrenalin given: ____:____ hrs* *If prescribed
NB ***Please copy this form and send to hospital with child if possible.***	Time ambulance called: ____:____ hrs Time ambulance arrived: ____:____ hrs

Trigger for reaction (i.e. food type / bee-sting)

Description of symptoms of reaction:

Any other notes about incident (e.g. child eating anything, injuries etc.)

Witnesses to incident:
(Position in setting)

Please circle the prescribed devise used: Emerade 150 Epipen Auto-injector 0.3mg Emerade 300 Epipen Jr Auto-injector 0.15mg Emerade 500 Jext 300mcg Jext 150mcg	Adrenalin given by: Site of injection: Problems encountered:

FORM COMPLETED BY:

NAME (print): …….....SIGNATURE: ……..

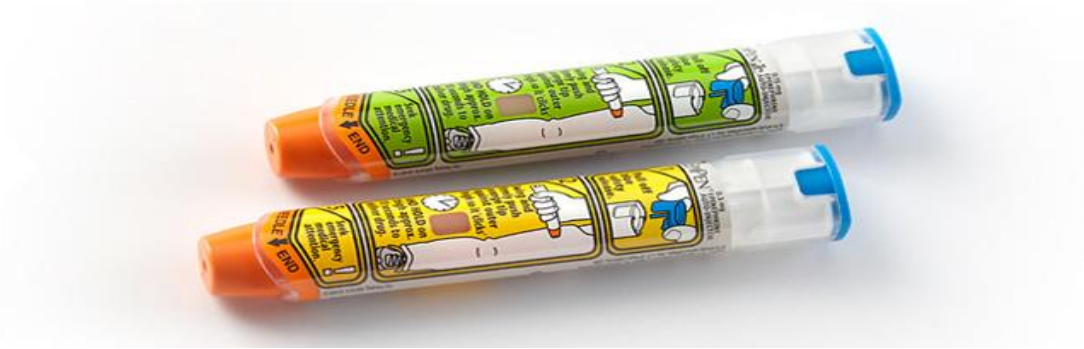
Job title: **…….**Telephone no: **……..**

DATE: ___/ ___ / 20____

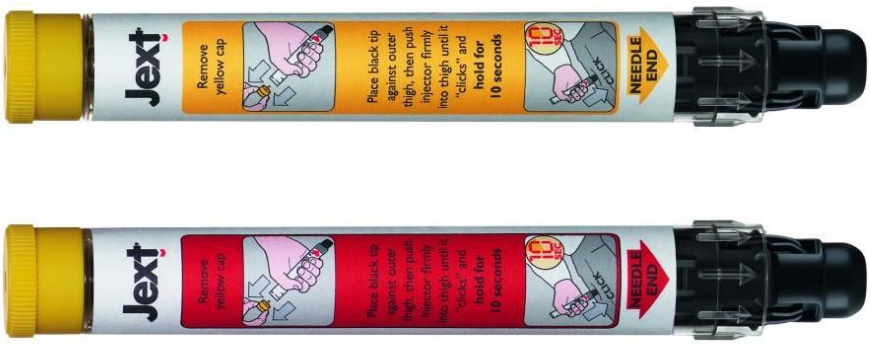
Please complete this Report Form, giving clear account of events and fax it to 0116 258 6694

Please keep original copy in setting records and give copy to parent

Epipen



Jext


Jext
Remove yellow cap
Place black tip against outer thigh, then push injector firmly into thigh until it "clicks" and hold for 10 seconds
CLICK
10
NEEDLE END
Jext
Remove yellow cap
Place black tip against outer thigh, then push injector firmly into thigh until it "clicks" and hold for 10 seconds
CLICK
10
NEEDLE END

Allergy: Emergency Action Plan with ***Antihistamine***

KNOWN ALLERGIES:

Name:

Preferred name:

Date of Birth:

Photo

Parent / Carer details:

1) ☎

2) ☎

Mild to Moderate Reaction:

- Swelling of lips, face, eyes
- Hives or itchy rash
- Itchy / tingling mouth / itchy throat
- Abdominal pain, vomiting

ACTION:

- Stay with the child
- Call for help if necessary
- Give antihistamine: CETIRIZINE
  If vomited, can give a further dose **(circle)**

<2yrs	2.5mg	2.5ml
2-6yrs	5mg	5ml
6+yrs	10mg	10ml or 1 tablet

- Contact parent / carer

Watch for signs of ANAPHYLAXIS
(Severe allergic reaction):

- Difficult or noisy breathing
- Wheeze / persistent cough / hoarse voice
- Difficulty swallowing / tightness in throat
- Loss of consciousness or collapse
- Pale / floppy / suddenly sleepy
- If in doubt or rapidly deteriorating

If ANY ONE of these signs are present:

- **Lie child flat.** If breathing is difficult, allow to sit
- **Dial 999 for an ambulance* and say ANAPHYLAXIS ("ANA-FIL-AX-IS")**
- **Stay with the child**

Additional instructions:
If asthmatic and concerns about breathing give 10 puffs of Salbutamol inhaler

*Medical observation in hospital for at least 6 hours is recommended after anaphylaxis (NICE Guidelines).

If (suspected) anaphylaxis please complete Report Form, giving clear account of events and fax it to 0116 2586694

Allergy: Emergency Action Plan with *Antihistamines*

This plan has been agreed by the following: (Block Capitals)

PARENT/GUARDIAN

NAME: ……. Tel No: ……

Signature: ……. Date _____ / _____ / 20_____

Emergency telephone contact number…….

HEAD OF ADMINISTERING SETTING

NAME: …….

Signature: ……. Date _____ / _____ / 20_____

VOLUNTEERS TO ADMINISTER ANTIHISTAMINE

NAME: …….

Signature: ……. Date _____ / _____ / 20_____

NAME: …….

Signature: ……. Date _____ / _____ / 20_____

NAME: …….

Signature: ……. Date _____ / _____ / 20_____

NAME: …….

Signature: ……. Date _____ / _____ / 20_____

PRESCRIBER COMPLETING EMERGENCY ACTION PLAN

NAME:……. Tel No:…….

Signature: ……. Date _____ / _____ / 20_____

Designation: ……...

The signature above only indicates that you have prescribed the medicine within this emergency action plan for the child. It is the LEA and schools' responsibility to ensure there is adequately trained staff able to instigate the management plan

PLEASE ENSURE ALL MEDICATIONS ARE IN DATE BY CHECKING THE EXPIRY DATE REGULARLY

Allergy: Emergency Action Plan with ***EpiPen®***

KNOWN ALLERGIES:

Name:

Preferred Name:

Date of Birth:

Photo

Parent / Carer details: 1)
☎

2)
☎

Mild to Moderate Reaction:

- ☐ Swelling of lips, face, eyes
- ☐ Hives or itchy rash
- ☐ Itchy / tingling mouth / itchy throat
- ☐ Abdominal pain, vomiting

ACTION:

- ☐ Stay with the child
- ☐ Call for help if necessary
- ☐ Give antihistamine: CETIRIZINE
  If vomited, can give a further dose (circle)
- ☐ Contact parent / carer
- ☐ Locate EpiPen®

<2yrs	2.5mg	2.5ml
2-6yrs	5mg	5ml
6+yrs	10mg	10ml or 1 tablet

Watch for signs of ANAPHYLAXIS
(Severe allergic reaction):

- ☐ Difficult or noisy breathing
- ☐ Wheeze / persistent cough / hoarse voice
- ☐ Difficulty swallowing / tightness in throat
- ☐ Loss of consciousness or collapse
- ☐ Pale / floppy / suddenly sleepy
- ☐ If in doubt or rapidly deteriorating

If ANY ONE of these signs are present:

- ☐ **Lie child flat.** If breathing is difficult, allow to sit
- ☐ **Give EpiPen® (circle) EpiPen® Jr EpiPen®**
- ☐ **Dial 999 for an ambulance* and say ANAPHYLAXIS ("ANA-FIL-AX-IS")**
- ☐ **Stay with the child**
- ☐ **If no improvement after 5-10 minutes, give a further EpiPen® dose (if prescribed)**

(please check overleaf)

Additional instructions:
If asthmatic and concerns about breathing give 10 puffs of Salbutamol inhaler

*Medical observation in hospital for at least 6 hours is recommended after anaphylaxis (NICE Guidelines).

If (suspected) anaphylaxis please complete Report Form, giving clear account of events and fax it to 0116 2586694

How to give EpiPen®

Step 1. Lie down with your leg slightly elevated or sit up if breathing is difficult

Step 2. Grasp your EpiPen® in your dominant hand with the blue safety cap closest to your thumb and remove cap

Step 3. Hold the EpiPen® about 10cm away from your leg, swing and jab the orange tip into the outer thigh. Hold in place for 10 seconds. Remove EpiPen®.

Step 4. Massage the injection area for 10 seconds. You must dial 999 immediately, ask for an ambulance and state anaphylaxis.

Keep your Epipen® device at room temperature.
For more information on Epipen® and to register for the free expiry alert service, go to www.epipen.co.uk.

This document has been adapted, with permission from the Australasian Society of Clinical Immunology and Allergy (ASCIA).

Allergy: Emergency Action Plan with *EpiPen*®

This plan has been agreed by the following: (Block Capitals)

PARENT/GUARDIAN

NAME: ……. Tel No: ……

Signature: ……. Date _____ / _____ / 20_____

Emergency telephone contact number…….

HEAD OF ADMINISTERING SETTING

NAME: …….

Signature: ……. Date _____ / _____ / 20_____

VOLUNTEERS TO ADMINISTER ANTIHISTAMINE

NAME: …….

Signature: ……. Date _____ / _____ / 20_____

NAME: …….

Signature: ……. Date _____ / _____ / 20_____

NAME: …….

Signature: ……. Date _____ / _____ / 20_____

NAME: …….

Signature: ……. Date _____ / _____ / 20_____

PRESCRIBER COMPLETING EMERGENCY ACTION PLAN

NAME:……. Tel No:…….

Signature: ……. Date _____ / _____ / 20_____

Designation: ……...

I have prescribed a second EpiPen® to be given (circle) Yes No

The signature above only indicates that you have prescribed the medicine within this emergency action plan for the child. It is the LEA and schools' responsibility to ensure there is adequately trained staff able to instigate the management plan.

PLEASE ENSURE ALL MEDICATIONS ARE IN DATE BY CHECKING THE EXPIRY DATE REGULARLY

Allergy: Emergency Action Plan with ***Jext®***

KNOWN ALLERGIES:

Name:

Preferred Name:

Date of Birth:

Photo

Parent / Carer details: 1)
☎

2)
☎

Mild to Moderate Reaction:

- ☐ Swelling of lips, face, eyes
- ☐ Hives or itchy rash
- ☐ Itchy / tingling mouth / itchy throat
- ☐ Abdominal pain, vomiting

ACTION:

- ☐ Stay with the child
- ☐ Call for help if necessary
- ☐ Give antihistamine: CETIRIZINE
  If vomited, can give a further dose (circle)
- ☐ Contact parent / carer
- ☐ Locate Jext®

<2yrs	2.5mg	2.5ml
2-6yrs	5mg	5ml
6+yrs	10mg	10ml or 1 tablet

Watch for signs of ANAPHYLAXIS
(Severe allergic reaction):

- ☐ Difficult or noisy breathing
- ☐ Wheeze / persistent cough / hoarse voice
- ☐ Difficulty swallowing / tightness in throat
- ☐ Loss of consciousness or collapse
- ☐ Pale / floppy / suddenly sleepy
- ☐ If in doubt or rapidly deteriorating

If ANY ONE of these signs are present:

- ☐ **Lie child flat.** If breathing is difficult, allow to sit
- ☐ **Give Jext® (circle) 150 micrograms 300 micrograms**
- ☐ **Dial 999 for an ambulance* and say ANAPHYLAXIS ("ANA-FIL-AX-IS")**
- ☐ **Stay with the child**
- ☐ **If no improvement after 5-10 minutes, give a further Jext® dose (if prescribed)**

(please check overleaf)

Additional instructions:
If asthmatic and concerns about breathing give 10 puffs of Salbutamol inhaler

*Medical observation in hospital for at least 6 hours is recommended after anaphylaxis (NICE Guidelines).

How to give Jext®

Step 1. Grasp the Jext® in your dominant hand as above. Pull off the yellow cap with the other hand.

Step 2. Place the black injector tip against outer thigh, holding the injector at a right angle to thigh.

Step 3. Push the black tip firmly into thigh until you hear a "click", then keep it pushed in. Hold firmly in place for 10 seconds then remove.

Step 4. Massage the injection area for 10 seconds. Seek immediate medical help by dialling 999 for an ambulance.

For more information on Jext® and to register for the free expiry alert service, go to www.jext.co.uk.

This document has been adapted, with permission from the Australasian Society of Clinical Immunology and Allergy (ASCIA).

If (suspected) anaphylaxis please complete Report Form, giving clear account of events and fax it to 0116 2586694

MUST BE COMPLETED BY HEALTH CARE PROFESSIONALS (WITH THE EXCEPTION OF THE OTHER SIGNATORIES)

Allergy: Emergency Action Plan with *Jext*®

This plan has been agreed by the following: (Block Capitals)

PARENT/GUARDIAN

NAME: …… Tel No: ……

Signature: …… Date _____ / _____ / 20_____

Emergency telephone contact number……

HEAD OF ADMINISTERING SETTING

NAME: ……

Signature: …… Date _____ / _____ / 20_____

VOLUNTEERS TO ADMINISTER ANTIHISTAMINE

NAME: ……

Signature: …… Date _____ / _____ / 20_____

NAME: ……

Signature: …… Date _____ / _____ / 20_____

NAME: ……

Signature: …… Date _____ / _____ / 20_____

NAME: ……

Signature: …… Date _____ / _____ / 20_____

PRESCRIBER COMPLETING EMERGENCY ACTION PLAN

NAME:…… Tel No:……

Signature: …… Date _____ / _____ / 20_____

Designation: ……...

I have prescribed a second Jext® to be given (circle) Yes No

The signature above only indicates that you have prescribed the medicine within this emergency action plan for the child. It is the LEA and schools' responsibility to ensure there is adequately trained staff able to instigate the management plan.

PLEASE ENSURE ALL MEDICATIONS ARE IN DATE BY CHECKING THE EXPIRY DATE REGULARLY

Allergy: Emergency Action Plan (page 3)

VOLUNTEERS TO ADMINISTER ANTIHISTAMINE AND PRE-PREPARED ADRENALINE.

NAME: .....

Signature: ..... Date _____ / _____ / 20_____

NAME: .....

Signature: ..... Date _____ / _____ / 20_____

NAME: .....

Signature: ..... Date _____ / _____ / 20_____

NAME: .....

Signature: ..... Date _____ / _____ / 20_____

NAME: .....

Signature: ..... Date _____ / _____ / 20_____

NAME: .....

Signature: ..... Date _____ / _____ / 20_____

NAME: .....

Signature: ..... Date _____ / _____ / 20_____

NAME: .....

Signature: ..... Date _____ / _____ / 20_____

NAME: .....

Signature: ..... Date _____ / _____ / 20_____

NAME: .....

Signature: ..... Date _____ / _____ / 20_____

NAME: .....

Signature: ..... Date _____ / _____ / 20_____

NAME: .....

Signature: ..... Date _____ / _____ / 20_____

NAME: .....

Signature: ..... Date _____ / _____ / 20_____

NAME: .....

Signature: ..... Date _____ / _____ / 20_____

NAME: .....

Signature: ..... Date _____ / _____ / 20_____