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.