



☐ Initial PAI

☐ Updated PAI

☐ Indefinite duration

☐ Valid for

PAI - Individualised Support Plan WASP & BEE STING ALLERGY



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Your rights regarding your personal data:

The information about you collected from this form needs to be processed by the public administration concerned.

That information is kept by the administration in question for as long as it is required to achieve the purpose of the processing operation(s).

Your data will be shared with other public administrations that are necessary for the processing of your application. For details on which departments will have access to the data on this form, please contact the public administration you are filing your application with.

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1. Input

Fields marked with an * are mandatory

Identity of the applicant

Photo

ONLY for School Medical Service:

Child's/Student's family name(s):*

Child's/Student's first name(s):*

Nat. identification number(matricule):*
(or date of birth if no id number)

Cycle / class:

School/SEA:*

Place/Location:*

Name(s) of legal
representative/parents:*

Address:*

Telephone:

Email address:

Child's/Student's family name(s):

Nat. identification number:



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Delegation of care

Fields marked with an * are mandatory

I,*

the undersigned, legal representative or adult student, request for my child or myself the implementing of an Individualised Support Plan (PAI) based on the medical prescription and emergency intervention protocol established by

Dr*

I authorise that this document be made known and applied by the people in charge of the student/child or myself : school, school health team, day care centre/SEA, SePAS.

It is my responsibility:

- to check the expiry date of medicines
- to replace them as soon as they reach the expiry date
- in the event of a change in the medical prescription, to inform the people responsible for the child/student and the school health team

Signature (mandatory)

Place:*

Date:*

Signature of legal
representative or adult
student:*

Prescribing physician

Name:*

Date:*

Signature:*

For the doctor at the National Health Directorate - Department for School Medicine and Health of Children and Young People

PAI received on:

forwarded to:

on:

Signature:



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2. Supervisory staff

School health team	Name	Job title	Tel. no.
Headteachers	Name	Job title	Tel. no.
Supervisory staff at day-care centre	Name	Job title	Tel. no.
SePAS/ESEB	Name	Job title	Tel. no.
Others	Name	Job title	Tel. no.

3. Doctors treating the child

Family doctor (GP)	Name	Address	Tel. no.
Specialists	Name	Address	Tel. no.



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4. Transmission of the PAI / Concertation meeting

Information session:

Date:

Attendance list - People who have knowledge of the PAI

(give names and job titles of all people who have knowledge of the PAI)

Job title	Family name/First name	Signature	Date
Head teacher			
Educator			
Person in charge of the day-care centre			
Staff at day-care centre			
SEPAS			
ESEB			
Others			
Others			
Others			

For the School Health Team

A copy of the PAI has been handed to:

Date:

IMPORTANT: Instructions for staff responsible for the child/student:

- Please inform the school principals in basic/secondary education establishments, the teachers, the supervisory staff and the supply teachers of the existence of this document.
- Send a copy of this page to *Division de la Médecine scolaire* (by post to: 20 Rue de Bitbourg, L-1273 Luxembourg-Hamm) after the people concerned have read the PAI and their signatures have been obtained.



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5. Instructions

1. Emergency kit

PLACE A COPY OF THIS DOCUMENT IN THE EMERGENCY KIT

Content / Medicines	Expiry date
Location	
School <input type="checkbox"/>	
Day-care centre/SEA <input type="checkbox"/>	
Other <input type="checkbox"/>	

- IF THE SAMU EMERGENCY SERVICE IS CALLED, INFORM THEM OF THE EXISTENCE OF THIS DOCUMENT
- INFORM THE PARENTS
- THE EMERGENCY KIT MUST FOLLOW THE CHILD ON ALL JOURNEYS OUTSIDE THE SCHOOL

2. USE OF ADRENALIN AUTO-INJECTOR

☐ YES (please fill in page 6 or 7)

☐ NO



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6a. EMERGENCY ACTION PLAN – WASP & BEE STING ALLERGY

If use of an **ADRENALIN AUTO-INJECTOR** is necessary, and in case of **FASTJEKT** or **EPIPEN**, please fill in this page.

IN THE EVENT OF THE CHILD BEING STUNG BY A WASP OR BEE:

SEVERE REACTION:

- Hoarse voice, voice changes
- Difficulty speaking
- Difficult breathing, wheeze, cough
- Severe abdominal pain and/or vomiting
- Feeling unwell, discomfort, faintness

WARNING!

IT MAY BE SERIOUS.

QUICKLY, PLEASE DO THE RIGHT THINGS NOW

1. INJECT FASTJEKT or EPIPEN:



Remove the blue cap



Place the orange end 5 cm from the top to the outer thigh, at a right angle



Push firmly against the thigh until a click is heard, and hold in place for 10 seconds



Massage the injection site for 10 seconds

2. CALL THE SAMU EMERGENCY SERVICE 112

3. Lay the child down and elevate the legs, or let the child sit up if breathing is difficult.

2nd injection in other thigh if no improvement after 10-15 minutes. ☐ YES ☐ NO

4. BREATHING ASSISTANCE

- Short-acting beta agonist (bronchodilators) administered using a spacer device:

- Corticosteroid administered orally:

MILD REACTION:

- My lips are swelling
- I have red itchy spots on my body
- My stomach hurts a little, I feel nauseous
- Large local swelling

WARNING!

NORMAL SPEAKING AND BREATHING

1. Antihistamine:

2. Corticosteroids for local or oral use:

3. Keep the child under observation and notify the parents

4. If the child's condition deteriorates: treat as a severe reaction; if no adrenaline was prescribed, call SAMU 112

*protocol validated by the Luxembourg Society for Allergology and Immunology

Signature

Place:*

Date:*

Stamp of the doctor:*

Child's/Student's family name(s):

Nat. identification number:



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6b. EMERGENCY ACTION PLAN – WASP & BEE STING ALLERGY

If use of an **ADRENALIN AUTO-INJECTOR** is necessary, and in case of **ANAPEN**, please fill in this page.

IN THE EVENT OF THE CHILD BEING STUNG BY A WASP OR BEE:

SEVERE REACTION:

- Hoarse voice, voice changes
- Difficulty speaking
- Difficult breathing, wheeze, cough
- Severe abdominal pain and/or vomiting
- Feeling unwell, discomfort, faintness

WARNING!

IT MAY BE SERIOUS.

QUICKLY, PLEASE DO THE RIGHT THINGS NOW

1. INJECT ANAPEN:



Remove the black cap
protecting the needle by
pulling hard



Press firmly against the thigh



Pull the grey safety cap off
the red firing button



Keep pressing against the thigh,
and press on the firing button
(you should hear it click); hold
down for 10 seconds, then
massage the injection site

2. CALL THE SAMU EMERGENCY SERVICE 112

3. Lay the child down and elevate the legs, or let the child sit up if breathing is difficult.

2nd injection in other thigh if no improvement after 10-15 minutes.

☐ YES

☐ NO

4. BREATHING ASSISTANCE

- Short-acting beta agonist (bronchodilators)
administered using a spacer device:

- Corticosteroid administered orally:

MILD REACTION:

- My lips are swelling
- I have red itchy spots on my body
- My stomach hurts a little, I feel nauseous
- Large local swelling

WARNING!

NORMAL SPEAKING AND BREATHING

1. Antihistamine:

2. Corticosteroids for local or oral use:

3. Keep the child under observation and notify the parents

4. If the child's condition deteriorates: *treat as a severe reaction*; if no adrenaline was prescribed, call SAMU 112

*protocol validated by the Luxembourg Society for Allergy and Immunology

Signature

Place:*

Date:*

Stamp of the doctor:*