Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

Student's Name: _____ D.O.B. _____ Grade: _____

School: _____ Teacher: _____

ALLERGY TO: _____

HISTORY: _____

_____

Asthma: ☐ YES (higher risk for severe reaction) – refer to their asthma care plan

☐ NO

Place child's photo here

To be completed by healthcare provider

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:

LUNG: Short of breath, wheeze, repetitive cough
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Swelling of the tongue and/or lips
HEART: Pale, blue, faint, weak pulse, dizzy
SKIN: Many hives over body, widespread redness
GUT: Vomiting or diarrhea (if severe or combined with other symptoms
OTHER: Feeling something bad is about to happen, Confusion, agitation

→

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
   - Ask for ambulance with epinephrine
   - Tell EMS when epinephrine was given
3. Stay with child and
   - Call parent/guardian and school nurse
   - If symptoms don't improve or worsen give second dose of epi if available as instructed below
   - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinphrine. **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

NOSE: Itchy, runny nose, sneezing
SKIN: A few hives, mild itch
GUT: Mild nausea/discomfort

→

1. Stay with child and
   - Alert parent and school nurse
   - Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and follow directions in above box

DOSAGE: **Epinephrine**: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve ____ minutes or more, or symptoms return, 2nd dose of epinephrine should be given if available

Antihistamine: (brand and dose)_____

Asthma Rescue Inhaler (brand and dose)_____

Student has been instructed and is capable of carrying and self-administering own medication. ☐Yes ☐No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an anaphylactic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: _____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. _____ 1) _____ 2) _____
   b. _____ 1) _____ 2) _____

DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

Student Name: _____ **DOB:** _____

Staff trained and delegated to administer emergency medications in this plan:

1._____ Room _____

2._____ Room _____

3._____ Room _____

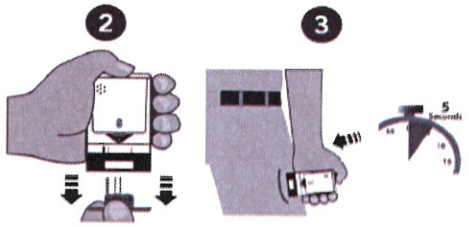
Self-carry contract on file: ☐Yes ☐No

Expiration date of epinephrine auto injector: _____

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.

AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.

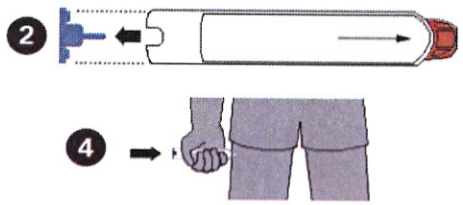


ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.

EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



If this conditions warrents meal accomodations from food service, please complete the form for dietary disabilitiy if required by district policy.

Additional information:_____

_____

_____

_____

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017

Allergy Self Carry Contract **School:** _____ **Grade:** _____

STUDENT : _____ **DOB:** _____

☐ I plan to keep my Epi-pen with me at school rather than in the school health office.

☐ I agree to use my Epi-pen in a responsible manner, in accordance with my physician's orders.

☐ I will notify the school health office immediately if my Epi-pen has been used.

☐ I will not allow any other person to use my Epi-pen.

Student's Signature _____ Date _____

PARENT/GUARDIAN: _____

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and that the medication has not expired.

☐ It has been recommended to me that a back-up Epi-pen be provided to the Health Office for emergencies.

☐ I will review the status of the student's allergy with the student on a regular basis as agreed in the health care plan.

☐ I will provide the school a signed medication authorization for this medication.

Guardian's Signature _____ Date _____

Nurse Consultant _____ **School** _____

☐ The above student has demonstrated correct technique for Epi-pen use, an understanding of the physician order for emergency use of the Epi-pen .

☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.

☐ I will review the medication authorization provided by the parent and signed by the parent and health care provider.

Nurse Consultant's Signature _____ Date _____

School Administrator's Signature: _____ Date: _____

Teacher's Signature: _____ Date: _____

Teacher's Signature: _____ Date: _____

Health Assistant Signature: _____ Date: _____

Allergy Self Carry Contract **School:** _____ **Grade:** _____

STUDENT

☐ I plan to keep my Epi-pen with me at school rather than in the school health office.

☐ I agree to use my Epi-pen in a responsible manner, in accordance with my physician's orders.

☐ I will notify the school health office immediately if my Epi-pen has been used.

☐ I will not allow any other person to use my Epi-pen.

Student's Signature _____ Date _____

PARENT/GUARDIAN

Este contrato estará en efecto el presente año escolar a menos que el doctor del estudiante lo revoque o que el estudiante falle en cumplir las contingencias propuestas en el párrafo anterior.

☐ Estoy de acuerdo en ver que mi niño/a lleve la medicación prescripta, que el dispositivo contenga medicina, y que este al día.
☐ Se me ha recomendado que un Epi-pen de emergencia sea provisto al Oficial de Salud para casos de emergencia.
☐ Revisaré el estado de las alergias del estudiante regularmente como fue aceptado en el plan de salud.
☐ Proveeré a la escuela la autorización firmada por el proveedor de salud autorizando el uso de la medicación.

Firma del padre _____ Fecha _____

Health Office Staff

☐ The above student has demonstrated correct technique for Epi-pen use, an understanding of the physician order for emergency use of the Epi-pen .

☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.
☐ I will review the medication authorization provided by the parent and signed by the parent and health care provider.

Nurse Consultant's Signature _____ Date _____

School Administrator's Signature: _____ Date: _____
Teacher's Signature: _____ Date: _____
Teacher's Signature: _____ Date: _____

Copy Sent to District Nurse Consultant