EMERGENCY ALLERGY CARE PLAN FOR STUDENT

NAME: ______________________________________ GRADE/SCHOOL: ____________________

ALLERGIES:

☐ GIVE EPINEPHRINE UPON EXPOSURE TO ABOVE ALLERGY OR

☐ GIVE EPINEPHRINE AT THE ONSET OF ANY OF THE BELOW SYMPTOMS IF ALLERGEN LIKELY EATEN (OR STUDENT STUNG)

SYMPTOMS OF ANAPHYLAXIS:

- Chest tightness, shortness of breath, cough, wheezing, profuse runny nose
- Dizzy, faint, pale, blue, confused
- Tightness and/or itching in throat, difficulty swallowing, hoarseness, drooling
- Swelling of lips, tongue, throat
- Itchy mouth, itchy skin, hives
- Hives, itching (anywhere), swelling (e.g. face, eyes)
- Nausea, vomiting, diarrhea, crampy pain

Insert Picture if available

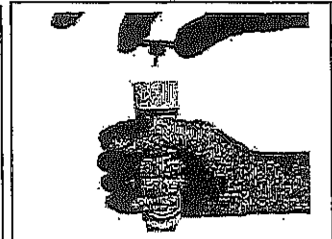
EPINEPHRINE ADMINISTRATION PROTOCOL:

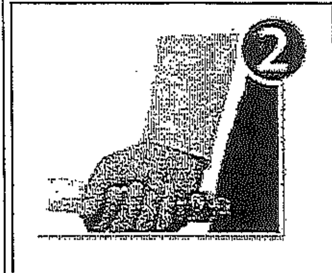
1. Administer Epinephrine Auto-Injector: **circle one: (0.15mg 0.3mg)**
2. Have someone call 911 for ambulance, don't hang up, and stay with student
3. Administer albuterol if authorized (has asthma)
4. Lie down if able; avoid rapid rise to upright position
5. Notify school and parent/guardian as soon as possible

EPI AUTO-INJECTOR DIRECTIONS:

For EPIPEN and EPIPEN JR.:

1. Stay Calm
2. Grip in your dominant hand as shown
3. Pull off blue activation cap.
4. Hold orange tip near outer thigh, OK to inject through clothing, but make sure pocket on that leg is empty.
5. Swing and jab firmly into outer thigh until you hear it click so you know it's injecting the medicine. Hold in place and count to 10; remove and massage 10 sec. (orange tip will automatically slide over needle)
6. Auto-injector should be given to EMS to take to E.R.





EMERGENCY CONTACTS

Name:

Relation:

Phone:

EMERGENCY/PHYSICIAN CONTACTS

Name:

Phone:

FOOD/INSECT EMERGENCY ANAPHYLAXIS CARE PLAN and MEDICATION AUTHORIZATION

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician's assistant, and for interscholastic and intramural sports only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a qualified school personnel to administer medication.

School: **District/Town:**

STUDENT INFORMATION

Student Name	**DOB:**
Home/Cell Phone	**Grade**

KNOWN LIFE-THREATENING ALLERGIES: ☐ PEANUTS ☐ TREE NUTS
☐ MILK ☐ SOY ☐ WHEAT ☐ SHELLFISH ☐ FISH (OTHER)
☐ BEE STINGS ☐ LATEX ☐ EGGS:____________ ☐ OTHER:
CONFIRMED WITH ALLERGY TESTING ☐ YES ☐ NO

History of Asthma? ☐ No ☐ Yes
(Increases risk of severe reaction)

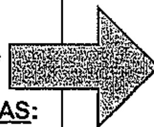
KNOWN ORAL ALLERGY SYNDROME: ☐ No ☐ Yes (list):
- Provide separate medication authorization if treatment indicated

Give epinephrine upon exposure (before the onset of any symptoms)
☐ If Yes

TREATMENT PLAN

AFTER EXPOSURE TO KNOWN OR SUSPECTED ALLERGY & ANY OF THESE SYMPTOMS:

AIRWAY: Difficulty breathing, swallowing, chest tightness, wheeze
THROAT: Tight, hoarse, swollen tongue, difficulty swallowing/drooling
CARDIAC: Dizzy, faint, confused, pale or blue, hypotension, weak pulse
&/OR
ANY COMBINATION OF SYMPTOMS FROM DIFFERENT BODY AREAS:
- Swollen lips, repetitive cough, sneezing, profuse runny nose
- Hives, itching (anywhere), swelling (e.g., eyes)
- Nausea, Vomiting, diarrhea, crampy pain



FOLLOW THIS PROTOCOL:

1. **INJECT EPINEPHRINE IMMEDIATELY!**
2. Call 911
3. Lie down if able, avoid rapid upright positioning & continue monitoring
4. Give Bronchodilator/Albuterol if has asthma
5. Notify Parent/Guardian
6. Notify Prescribing Provider / PCP
7. When indicated, assist student to rise very slowly.

EPINEPHRINE

☐ Epinephrine Auto-injector, Jr (0.15mg) IM side of thigh ☐ Epinephrine Auto-injector (0.3mg) IM side of thigh
- **A second dose** of epinephrine can be given 5 minutes or more if symptoms persist or recur.

Relevant Side Effects ☐ Tachycardia ☐ Other: **Medication Allergies** ☐ NKDA ☐ Other:

Medication shall be administered during school year:

NOTE: IF NURSE IS NOT AVAILABLE, THE EPINEPHRINE AUTO INJECTOR MAY BE GIVEN BY DESIGNATED SCHOOL PERSONNEL WITH EXPOSURE OR FOR ANY ANAPHYLAXIS SYMPTOMS

TO BE COMPLETED BY PARENT AND AUTHORIZED HEALTHCARE PROVIDER: REQUIRED

AUTHORIZATION

Prescriber's Authorization to Self- Administer ☐ No ☐ *Yes, *Confirms student is capable to safely and properly administer medication*

Prescriber's Signature: **Date:**

PRESCRIBER'S PRINTED NAME OR STAMP

Parent/Guardian Consent ☐ I authorize the student to **possess** and **self-administer** medication **OR**
☐ I authorize this medication to be **administered by school personnel**
- I also authorize communication between the prescribing health care provider and school nurse necessary for allergy management and administration of this medication

Signature: **Date:**

TURN OVER FORM FOR INSTRUCTIONS ON ADMINISTERING EPINEPHRINE