Allergy and Anaphylaxis Action Plan and Medication Orders

Place child's photo here

To be completed by healthcare provider

Student's Name: _____D.O.B. _____ Grade: _____
School: _____ Teacher: _____
ALLERGY TO: _____

_____

History: _____

_____

Asthma: ☐ YES (Higher risk for severe reaction) ☐ NO

◊ STEP 1: TREATMENT

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:
- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Obstructive swelling (tongue and/or lips)
- SKIN: Many hives over body

Or **combination** of symptoms from different body areas:
- SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
- GUT: Vomiting, crampy pain

→

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   - Antihistamine
   - Inhaler (quick relief) if asthma

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE

MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort

→

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

DOSAGE

Epinephrine: inject intramuscularly using autoinjector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ Administer 2nd dose if symptoms do not improve in _____minutes

Antihistamine: (brand and dose)_____

If Asthmatic: (brand and dose)_____

☐ Student's condition warrants accommodations from food service (please complete the bottom of the back page)

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 allergic 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) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; 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. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

Student Name: _____ **DOB:** _____

TRAINED/DELEGATED STAFF MEMBERS

1. _____ Room_____
2. _____ Room_____
3. _____ Room_____
4. _____ Room_____
5. _____ Room_____

Self-carry contract on file. ☐ Yes ☐ No Medication located in: _____

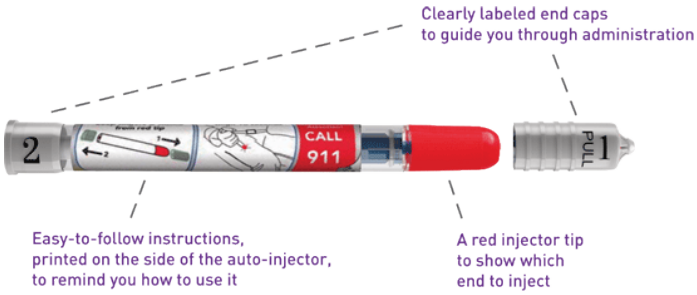
EpiPen® and EpiPen® Jr.
Expiration date: _____

- Pull off blue activation cap.

- Hold orange tip near outer thigh (through clothing, if needed)

- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Adrenaclick 0.3 mg. and 0.15 mg
Expiration date: _____



Auvi-Q 0.3 mg. and 0.15 mg
Expiration date: _____

- Pull the Auvi-Q™ from the outer case.
- Pull off Red safety guard.
- Place black end against the middle of the outer thigh (through clothing, if needed), then press firmly, and hold in place for 5 seconds.

Once epinephrine is used, call 911.
Student should remain lying down or in a comfortable position.

Additional information:_____

_____

_____

MEDICAL STATEMENT FOR SCHOOL MEAL MODIFICATION

☐ I certify that the student's food allergy rises to the level of a disability & qualifies for school meal modification.

1. List foods to be omitted: _____
2. Indicate food modification/substitutions: _____

_____

Signature by a licensed MD or DO only_____ Date_____