Allergy and Anaphylaxis Action Plan and Medication Orders

Place child's photo here

Student's Name: _____ D.O.B. _____ Grade: _____
School: _____ Teacher: _____
ALLERGY TO: _____
_____
History: _____
_____
Asthma: ☐YES (Higher risk for severe reaction) ☐NO

To be completed by healthcare provider

◊ STEP 1: TREATMENT ◊

SEVERE SYMPTOMS:
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

☐ **Give epinephrine immediately if the allergen was definitely ingested, even if there are no symptoms**

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

Provider (print) _____Phone Number: _____

Provider's Signature: _____ Date: _____

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

◊ 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:** _____

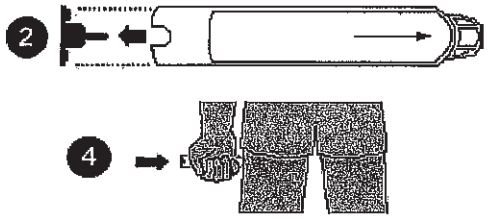
TRAINED/DELEGATED STAFF MEMBERS

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

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

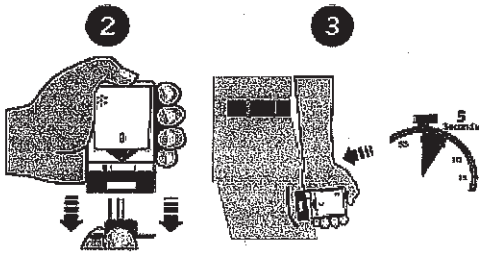
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



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 outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK™/ADRENACLICK™ GENERIC DIRECTIONS

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

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

Additional information:

ALLERGY & ANAPHYLAXIS HEALTH CARE PLAN
USE OF EMERGENCY MEDICATIONS TRAINING AND DELEGATION RECORD

School/Center		RN Instructor: Print	Initials:

PROCEDURE GUIDELINE	RN Initials/ Date	RN Initials /Date	RN Initials /Date
1. Confirms written authorization: Parent permission, Physician authorization, up to date Health Care Action Plan			
2. Verifies pharmacy labels for all prescribed medications. Checks expiration dates			
3. Verifies self carry contract			
4. Specific Care Training: • Describes difference between mild allergy and anaphylaxis symptoms • Identifies signs/symptoms indicating epinephrine use • Identifies signs/symptoms indicating antihistamine use • Identifies signs/symptoms indicating rescue inhaler use • States importance of monitoring for increased symptoms • Directs student to lie down and stay down • Confirms use of epinephrine ***first*** for potentially life threatening symptoms • Confirms importance of EMS activation • Indicates need/order for second dose of epinephrine • Identifies when to communicate with parent/guardian			
5. Describes documentation procedure			
6. Identifies process to communicate with RN			
7. Returns demonstration auto injector trainer and describes proper disposal			
8. Returns demonstration antihistamine administration			
9. Returns demonstration of rescue inhaler use			

I understand the need to confirm current health care action plan information for each student/child. I have had the opportunity to ask questions and received satisfactory answers.

Delegatee Name (Print)	Delegatee Signature	Date

Delegating RN Signature: _____ Initials _____