FOOD/INSECT EMERGENCY ALLERGY CARE PLAN and MEDICATION AUTHORIZATION

State Law and Regulations require a written medication order of an authorized prescriber, 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:	**History of Asthma?** ☐ No ☐ Yes (Increases risk of severe reaction)
KNOWN ORAL ALLERGY SYNDROME: ☐ No ☐Yes (list):	**Give epinephrine upon exposure (before the onset of any symptoms)** ☐ If Yes

➢ Provide separate medication authorization if treatment indicated

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 PRINTED NAME OR STAMP

Prescriber's Signature: **Date:**

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: