



SEVERE ALLERGY AND ANAPHYLAXIS EMERGENCY CARE PLAN

School Year _____

Student's weight: _____

Student Name: _____ D.O.B. _____

Allergy type(s) Food Insect Medication Environmental

Allergic to : _____

Check if Student has Asthma (higher risk for severe reaction)

Parent or guardian name/signature: _____ Phone: _____

Mild Symptoms

Print name _____ sign _____

If checked, give epinephrine immediately for **ANY** symptoms if the student was possibly exposed to the allergen.

MOUTH - Itchy mouth

NOSE - Itchy/Runny Nose, Sneezing

SKIN - A few hives, mild itch

Stomach - Mild nausea/discomfort

1. Give Antihistamines, if ordered by physician.

2. Stay with student; alert emergency contacts.

3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

Severe Symptoms

NOTE: Do not depend on antihistamine or inhalers to treat a severe reaction. **Use epinephrine.**

If checked, give epinephrine immediately if the student was definitely exposed to the allergen, even if there are no symptoms.

MOUTH - Itchy mouth, swelling of tongue/lips

Throat - Tight, hoarse, trouble breathing/swallow

SKIN - Many hives over a body, widespread redness

Stomach - Repetitive vomiting/severe diarrhea

LUNG - Short of breath, wheezing repetitive cough

HEART - Pale, blue, faint, weak pulse, dizzy

OTHER - Feeling of impending doom, anxiety,

confusion, or combination of mild or severe

symptoms from different body areas

1. Inject Epinephrine immediately!

2. Call 911. Request ambulance with epinephrine:

*Consider giving additional medications (following or with the epinephrine):

>Antihistamine

>Inhaler (bronchodilator) if asthma

*Lay student flat and raise legs.

*If breathing is difficult, or they are vomiting, let them sit up or lie on their side.

*Alert Emergency contacts.

*Transport student to ER even if symptoms resolve.

*Student should remain in ER for 4+ hours because symptoms may return.

Medication Orders

Epinephrine Brand/type Epipen 0.3 mg IM Epipen Jr 0.15 mg IM Auvi Q 0.3 mg IM Auvi Q 0.15 mg IM

If checked- repeat dosing if symptoms worsen, or do not improve after 5 minutes of initial dose.

Check box if generic substitute is not allowed. Must complete Authorization to Carry and Self Administer form to carry EpiPen.

Medication

Dose

Route

Frequency

Comments:

Authorization to Carry and Self-Administer Medication

Authorization to Carry and Self-Administer Epinephrine Auto-Injector - Must be completed by Health Care Provider

Student may carry and self-administer Epinephrine Auto-Injector Yes No If yes, must complete the following:

Student instructed on and verbalized understanding of the name, purpose, dose of medication.

Student instructed on disease process of anaphylaxis and verbalized understanding of when to take medication.

Student instructed on and verbalized understanding of his/her responsibility in carrying medication(s) and agrees not to share

Student demonstrated correct use/administration of medication.

I, the student, understand that I am responsible and accountable for using and carrying the above medication as prescribed. I also understand that if there is irresponsible behavior or a safety risk the privilege of carrying the above medication will be rescinded.

Student's Signature _____

Date _____

LHC Provider Name/Signature: _____

Date: _____

LHC Provider Office Number: _____

LHC Provider Fax: _____

Nurse's Signature: _____

Date: _____