Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders 2020/2021

Student's Name: _____D.O.B. _____ Grade: _____

School: _____ Teacher: _____

ALLERGY TO: _____

HISTORY:_____

_____

Asthma: ☐ YES (higher risk for severe reaction) – refer to their asthma care plan

☐ NO

Place child's photo here

To be completed by healthcare provider

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:

LUNG: Short of breath, wheeze, repetitive cough
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Swelling of the tongue and/or lips
HEART: Pale, blue, faint, weak pulse, dizzy
SKIN: Many hives over body, widespread redness
GUT: Vomiting or diarrhea (if severe or combined with other symptoms
OTHER: Feeling something bad is about to happen, Confusion, agitation

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
   - Ask for ambulance with epinephrine
   - Tell EMS when epinephrine was given
3. Stay with child and
   - Call parent/guardian and school nurse
   - If symptoms don't improve or worsen give second dose of epi if available as instructed below
   - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinphrine. **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

NOSE: Itchy, runny nose, sneezing
SKIN: A few hives, mild itch
GUT: Mild nausea/discomfort

1. Stay with child and
   - Alert parent and school nurse
   - Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and follow directions in above box

DOSAGE: **Epinephrine**: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve ____ minutes or more, or symptoms return, 2nd dose of epinephrine should be given if available

Antihistamine: (brand and dose)_____

Asthma Rescue Inhaler (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: _____

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an anaphylactic 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) _____

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 and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

Student Name: _____ **DOB:** _____

Staff trained and delegated to administer emergency medications in this plan:

1._____ Room _____

2._____ Room _____

3._____ Room _____

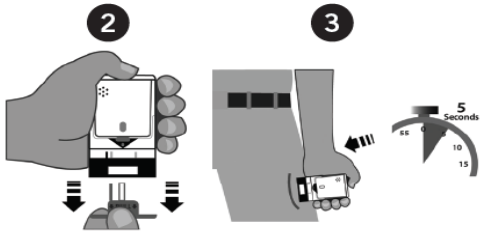
Self-carry contract on file: ☐Yes ☐No

Expiration date of epinephrine auto injector: _____

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.

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

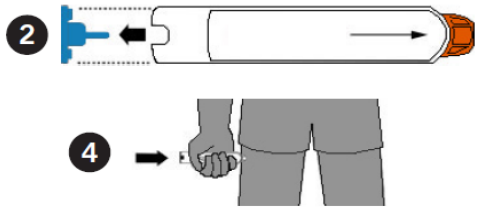


ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

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

EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



If this conditions warrents meal accomodations from food service, please complete the form for dietary disabilitiy if required by district policy.

Additional information:_____

_____

_____

_____

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017

EpiPen® Self Carry Contract – LPS 2020/2021

Name:	D.O.B.
School/Teacher:	Grade:

This contract between the school, the school nurse consultant, the student, and the student's parents or legal guardian will be established by assigning levels of responsibility for each individual. This contract will accompany the Health Care Action Plan for severe allergy management. All parties agree that noncompliance with the contract may result in withdrawal of the privilege.

STUDENT AGREEMENT

- ☐ I will not allow any classmate to have access to my medication.
- ☐ I will inform school staff whenever I feel I am having allergy symptoms, or my allergy reaction needs the administration of my EpiPen®, as outlined in my Health Care Action Plan.
- ☐ I will keep my medication: ☐ in my possession at all times ☐ in the school health office ☐ in an accessible and secure location (located in _____)

√ STUDENT SIGNATURE	PRINT STUDENT'S NAME	DATE
_____	_____	_____

PARENT/GUARDIAN AGREEMENT

This contract is in effect for the current school year unless revoked by the health care provider or the student fails to meet the above safety contingencies.

- ☐ I agree that my student can recognize potential life threatening allergic symptoms (anaphylaxis) as outlined in the Health Care Action Plan, and understands the importance of seeking immediate help of school staff member(s) that may assist in the administration of the EpiPen® and request for emergency personnel (911)
- ☐ I agree to see that my student carries his/her medication as prescribed, that the device contains medication, and the medication has not expired.
- ☐ I agree to provide backup medication to the health office: ☐ Antihistamine ☐ EpiPen®
- ☐ I agree to provide current emergency contact information to school staff.

√ PARENT/GUARDIAN SIGNATURE	PRINT PARENT/GUARDIAN NAME	DATE
_____	_____	_____

SCHOOL NURSE AGREEMENT

- ☐ I have assessed this student's ability to recognize potential life threatening allergic symptoms (anaphylaxis) as outlined in the health care plan, understand the importance of seeking immediate help of school staff member(s) that may assist in the administration of the EpiPen® and request for emergency personnel (911). I agree with the designated self care.
- ☐ The above student has demonstrated correct technique for EpiPen® use.
- ☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.

SCHOOL NURSE SIGNATURE	PRINT NURSE'S NAME	DATE
_____	_____	_____

DESIGNATED SCHOOL ADMINISTRATOR AGREEMENT

I am aware of this student's ability to recognize potential life threatening allergic symptoms (anaphylaxis) as outlined in the Health Care Action Plan, understand the importance of seeking immediate help of school staff member(s) that may assist in the administration of the EpiPen® and request for emergency personnel (911). I agree with the designated self care.

SCHOOL ADMINISTRATOR SIGNATURE	PRINT ADMINISTRATOR'S NAME	DATE
_____	_____	_____