Student Services

Health Care Action Plan – Allergies

Please return form to: School:_____ Fax: _____

Name: _____ DOB: _____

SEVERE ALLERGY TO:	

Symptoms and History of Reactions

Other allergies (food, insects, medication, etc.)

Medications provided to school for treatment of allergy

School accommodations and treatments (to be filled out by school nurse)

Emergency Information

List contacts in order of preference. Also, write preference of contact method, 1 being the highest, 3 the lowest.

Contact #1 name: _____ Contact #2 name: _____

Home: _____ Preference: ____ Home: _____ Preference: ____

Cell phone: _____ Preference: ____ Cell phone: _____ Preference: ____

Work phone: _____ Preference: ____ Work phone: _____ Preference: ____

Health Care Provider who should be contacted regarding the allergic reaction:

Name:_____ Phone: _____

_____

Parent/Guardian Signature *Date* *School Nurse Signature* *Date*

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

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

Place child's photo here

◊ STEP 1: TREATMENT

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

SEVERE SYMPTOMS: Any of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy,
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Significant swelling of the tongue and/or lips
SKIN: Many hives over body, widespread redness
GUT: Repetitive vomiting, severe diarrhea
OTHER: Feeling something bad is about to happen, confusion

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1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911 and activate school emergency response team
3. Call parent/guardian and school nurse
4. Monitor student; keep them lying down
5. Administer Inhaler (quick relief) if ordered
6. Be prepared to administer 2nd dose of epinephrine if needed

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe food related reaction . **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

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

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1. Alert parent/guardian and school nurse
2. Antihistamines may be given if ordered by a healthcare provider,
3. Continue to observe student
4. If symptoms progress **USE EPINEPHRINE**
5. 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 in _____ minutes, or if 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: _____

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 _____

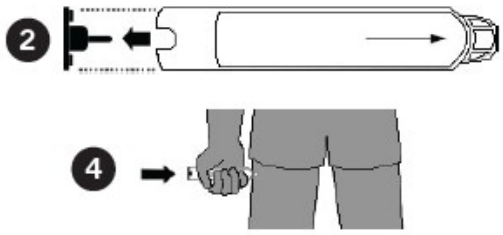
Self-carry contract on file. ☐Yes ☐No

Location of Medication: _____

EXPIRATION DATE OF EPINEPHRINE AUTO INJECTOR: _____

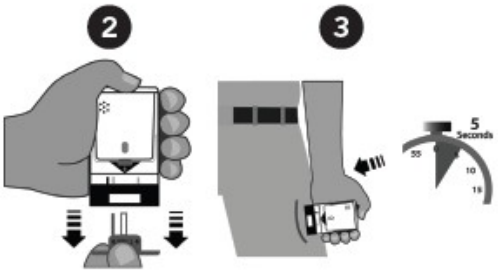
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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.

NOTE: Consider lying on the back with legs elevated. Alternative positioning may be needed for vomiting (side lying, head to side) or difficulty breathing (sitting)

Additional information: _____

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