

# Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

Student's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_

**ALLERGY TO:** \_\_\_\_\_

**HISTORY:** \_\_\_\_\_



**Asthma:**  YES (higher risk for severe reaction)  NO

## ◇ STEP 1: TREATMENT ◇

**SEVERE SYMPTOMS:** Any of the following:

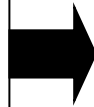
- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy,
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Significant swelling of the tongue and/or lips
- SKIN: Many hives over body, widespread redness
- GUT: Repetitive vomiting, severe diarrhea
-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



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 2<sup>nd</sup> 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



1. Alert parent 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 \_\_\_\_\_ minutes or more, or symptoms return, 2<sup>nd</sup> dose of epinephrine should be given

**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: \_\_\_\_\_

To be completed by healthcare provider

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

1. \_\_\_\_\_

Room \_\_\_\_\_

2. \_\_\_\_\_

Room \_\_\_\_\_

3. \_\_\_\_\_

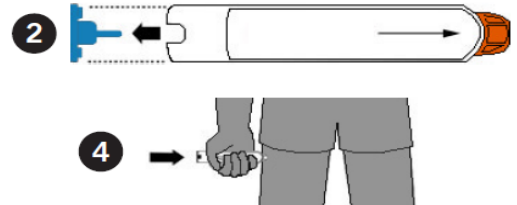
Room \_\_\_\_\_

Self-carry contract on file:  Yes  No

Expiration date of epinephrine auto injector: \_\_\_\_\_

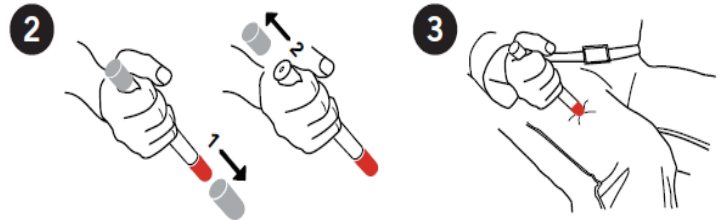
### EPIPEN® AUTO-INJECTOR DIRECTIONS

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.



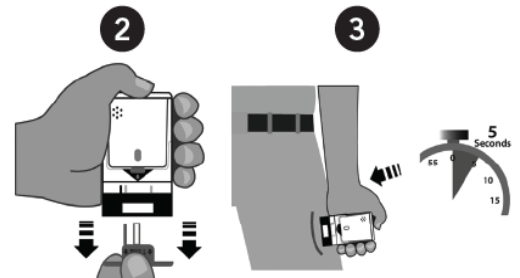
### ADRENALICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

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.



### 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.



**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

## Family Food Allergy Health History Form

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Primary Healthcare Provider: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Allergist: \_\_\_\_\_ Phone: \_\_\_\_\_

1. Does your child have a diagnosis of an allergy from a healthcare provider:  No  Yes

### 2. History and Current Status

<p>a. What is your child allergic to?</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Peanuts</td> <td><input type="checkbox"/> Insect Stings</td> </tr> <tr> <td><input type="checkbox"/> Eggs</td> <td><input type="checkbox"/> Fish/Shellfish</td> </tr> <tr> <td><input type="checkbox"/> Milk</td> <td><input type="checkbox"/> Chemicals _____</td> </tr> <tr> <td><input type="checkbox"/> Latex</td> <td><input type="checkbox"/> Vapors _____</td> </tr> <tr> <td><input type="checkbox"/> Soy</td> <td><input type="checkbox"/> Tree Nuts (walnuts, pecans, etc.)</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Insect Stings	<input type="checkbox"/> Eggs	<input type="checkbox"/> Fish/Shellfish	<input type="checkbox"/> Milk	<input type="checkbox"/> Chemicals _____	<input type="checkbox"/> Latex	<input type="checkbox"/> Vapors _____	<input type="checkbox"/> Soy	<input type="checkbox"/> Tree Nuts (walnuts, pecans, etc.)	<input type="checkbox"/> Other: _____		<p>b. Age of student when allergy first discovered: _____</p> <p>c. How many times has student had a reaction?  <input type="checkbox"/> Never <input type="checkbox"/> Once <input type="checkbox"/> More than once, explain:        _____</p> <p>d. Explain their past reaction(s): _____</p> <p>e. Symptoms: _____</p> <p>f. Are the food allergy reactions: <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worse</p>
<input type="checkbox"/> Peanuts	<input type="checkbox"/> Insect Stings												
<input type="checkbox"/> Eggs	<input type="checkbox"/> Fish/Shellfish												
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<input type="checkbox"/> Latex	<input type="checkbox"/> Vapors _____												
<input type="checkbox"/> Soy	<input type="checkbox"/> Tree Nuts (walnuts, pecans, etc.)												
<input type="checkbox"/> Other: _____													

### 3. Trigger and Symptoms

- a. What are the early signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)* \_\_\_\_\_
- b. How does your child communicate his/her symptoms? \_\_\_\_\_
- c. How quickly do symptoms appear after exposure to food(s)? \_\_\_\_\_secs. \_\_\_\_\_mins. \_\_\_\_\_hrs. \_\_\_\_\_days
- d. Please check the symptoms that your child has experienced in the past:
- |                   |  |   |   |                                   |   |
|-------------------|--|---|---|-----------------------------------|---|
| <b>Skin:</b>      | <input type="checkbox"/> Hives               | <input type="checkbox"/> Itching                        | <input type="checkbox"/> Rash             | <input type="checkbox"/> Flushing | <input type="checkbox"/> Swelling (face, arms, hands, legs) |
| <b>Mouth:</b>     | <input type="checkbox"/> Itching             | <input type="checkbox"/> Swelling (lips, tongue, mouth) |   |                                   |   |
| <b>Abdominal:</b> | <input type="checkbox"/> Nausea              | <input type="checkbox"/> Cramps                         | <input type="checkbox"/> Vomiting         | <input type="checkbox"/> Diarrhea |   |
| <b>Throat:</b>    | <input type="checkbox"/> Itching             | <input type="checkbox"/> Tightness                      | <input type="checkbox"/> Hoarseness       | <input type="checkbox"/> Cough    |   |
| <b>Lungs:</b>     | <input type="checkbox"/> Shortness of breath |   | <input type="checkbox"/> Repetitive Cough | <input type="checkbox"/> Wheezing |   |
| <b>Heart:</b>     | <input type="checkbox"/> Weak pulse          | <input type="checkbox"/> Loss of consciousness          |   |                                   |   |

### 4. Treatment

<p>a. How have past reactions been treated? _____</p> <p>b. How effective was the student's response to treatment? _____</p> <p>c. Was there an emergency room visit? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain: _____</p> <p>d. Was the student admitted to the hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain: _____</p> <p>e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction?        _____</p> <p>f. Has your healthcare provider provided you with a prescription for medication? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>g. Have you used the treatment or medication? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>h. Please describe any side effects or problems your child had in using the suggested treatment: _____</p> <p>_____</p>
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**5. Self Care**

a. Is your student able to monitor and prevent their own exposures?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. Does your student:		
1. Know what foods to avoid	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Ask about food ingredients	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3. Read and understands food labels	<input type="checkbox"/> No	<input type="checkbox"/> Yes
4. Tell an adult immediately after an exposure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5. Wear a medical alert bracelet, necklace, watchband	<input type="checkbox"/> No	<input type="checkbox"/> Yes
6. Tell peers and adults about the allergy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
7. Firmly refuses a problem food	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Does your child know how to use emergency medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
d. Has your child ever administered their own emergency medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____

**6. Family / Home**

a. How do you feel that the whole family is coping with your student's food allergy?	_____
b. Does your child carry epinephrine in the event of a reaction?	<input type="checkbox"/> No <input type="checkbox"/> Yes
c. Has your child ever needed to administer that epinephrine?	<input type="checkbox"/> No <input type="checkbox"/> Yes
d. Do you feel that your child needs assistance in coping with his/her food allergy?	_____

**7. General Health**

a. How is your child's general health other than having a food allergy?	_____
b. Does your child have other health conditions?	_____
c. Hospitalizations?	_____
d. Does your child have a history of asthma?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, does he/she have an Asthma Action Plan?	<input type="checkbox"/> No <input type="checkbox"/> Yes
e. Please add anything else you would like the school to know about your child's health:	_____ _____

**8. Notes:**

**Parent / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed by R.N.:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Allergy Self Carry Contract      The Vanguard School 2020-2021      Grade: \_\_\_\_\_**

**STUDENT :** \_\_\_\_\_ **DOB:** \_\_\_\_\_

- I plan to keep my Epi-pen with me at school rather than in the school health office.
- I agree to use my Epi-pen in a responsible manner, in accordance with my physician's orders.
- I will notify the school health office immediately if my Epi-pen has been used.
- I will not allow any other person to use my Epi-pen.

Student's Signature: \_\_\_\_\_ Date \_\_\_\_\_

**PARENT/GUARDIAN:** \_\_\_\_\_

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

- I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and that the medication has not expired.
- It has been recommended to me that a back-up Epi-pen be provided to the Health Office for emergencies.
- I will review the status of the student's allergy with the student on a regular basis as agreed in the health care plan.
- I will provide the school a signed medication authorization for this medication.

Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**School Nurse/RN: Robin Smith, RN BSN The Vanguard School**

- The above student has demonstrated correct technique for Epi-pen use, an understanding of the physician order for emergency use of the Epi-pen .
- School staff that have the need to know about the student's condition and the need to carry medication have been notified.
- I will review the medication authorization provided by the parent and signed by the parent and health care provider.

School Nurse/RN's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health Assistant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Administrator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_