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

◊ 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 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

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, 2nd 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: ______________

Student Name: ______________________________ DOB: ______________________

1.______________________________ Room ______________________

2.______________________________ Room ______________________

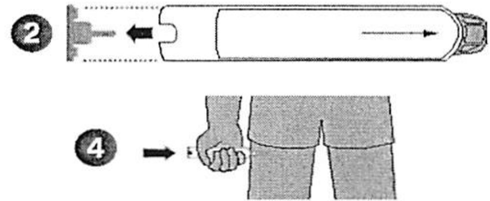
3.______________________________ Room ______________________

Self-carry contract on file: ☐Yes ☐No

Expiration date of epinephrine auto injector: ______________________

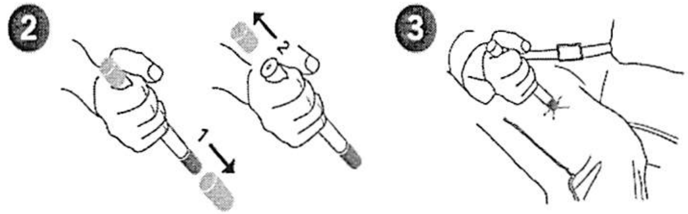
EPIPEN® AUTO-INJECTOR DIRECTIONS

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.



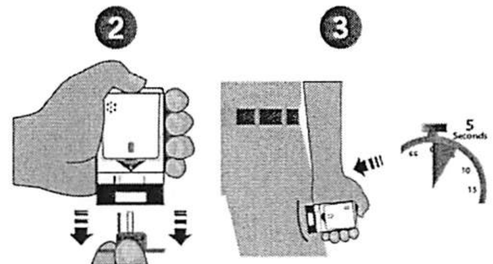
ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

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.



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

Allergy Self Carry Contract **School:** ____________________ **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 ______________

Nurse Consultant ______________________ **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.

Nurse Consultant's Signature ____________________ Date ______________

School Administrator's Signature: ______________________ Date: ______________
Teacher's Signature: ______________________________ Date: ______________
Teacher's Signature: ______________________________ Date: ______________
Health Assistant Signature: ________________________ Date: ______________