

FOOD/INSECT & EMERGENCY ALLERGY CARE PLAN and MEDICATION AUTHORIZATION

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician's assistant, and for interscholastic and intramural sports only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a qualified school personnel to administer medication.

Choose School

Choose School System

STUDENT INFORMATION	Student Name	DOB:
	Home/Cell Phone	Grade
	Known Life-Threatening Allergies: Diagnosis of Oral Allergy Syndrome? <input type="checkbox"/> No <input type="checkbox"/> Yes Please list allergens:	History of Asthma? <input type="checkbox"/> No <input type="checkbox"/> Yes (Asthma may indicate an increased risk of severe reaction) <hr/> History of SEVERE Anaphylactic Reaction? <input type="checkbox"/> No <input type="checkbox"/> Yes, If checked YES, give epipen immediately if allergen was <i>likely</i> eaten, at onset of <i>any</i> symptoms, and follow the protocol below

TREATMENT PLAN	ANY ONE OF THESE SEVERE SYMPTOMS OF ANAPHYLAXIS AFTER SUSPECTED OR KNOWN INGESTION: > Difficulty breathing or swallowing > Dizzy, faint, confused, pale or blue, hypotension/weak pulse &/OR ANY COMBINATION OF SYMPTOMS FROM DIFFERENT BODY AREAS: AIRWAY: Short of breath, chest tightness, wheeze, repetitive cough, profuse runny nose THROAT: Tight, hoarse, trouble breathing/swallowing, drooling MOUTH: Swollen lips or tongue SKIN: Hives, Itchy rashes, swelling (e.g., eyes, lips) GUT: Nausea, Vomiting, diarrhea, crampy pain ORAL ALLERGY SYNDROME (IF DIAGNOSIS CONFIRMED ABOVE): MOUTH: Itchy mouth, lips, tongue and/or throat SKIN: Itching just around mouth	FOLLOW THIS PROTOCOL: 1. INJECT EPINEPHRINE IMMEDIATELY! 2. Call 911 3. Raise feet above the head, remain lying down & continue monitoring 4. Give additional medications as ordered - Antihistamine - Bronchodilator/Albuterol if has asthma 5. Notify Parent/Guardian 6. Notify Prescribing Provider / PCP 7. When indicated, assist student to rise slowly. 1. GIVE ANTIHISTAMINE (swish, gargle, & swallow) 2. Monitor student as indicated; notify healthcare provider & parent as indicated 3. If progresses to symptoms of anaphylaxis, USE EPINEPHRINE (as stated above)
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> THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL SYMPTOMS OF ANAPHYLAXIS CAN POTENTIALLY PROGRESS TO A LIFE THREATENING SITUATION!!

DOSAGE OF MEDICATIONS	Epinephrine	<input type="checkbox"/> Epi Auto-injector, Jr (0.15mg) inject intramuscularly <input type="checkbox"/> Epi Auto-injector (0.3mg) inject intramuscularly > A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.		
	Antihistamine	<input type="checkbox"/> Benadryl/Diphenhydramine Frequency: Dose: <input type="checkbox"/> AFTER Route: PO	<input type="checkbox"/> Other Dose: Route:	Relevant Side Effects <input type="checkbox"/> Tachycardia <input type="checkbox"/> Other
	Medication shall be administered during school year:	2015 TO 2016		

NOTE: IF NURSE IS NOT AVAILABLE, THE EPINEPHRINE AUTO INJECTOR MAY BE GIVEN BY DESIGNATED SCHOOL PERSONNEL FOR ANY ANAPHYLAXIS SYMPTOMS

TO BE COMPLETED BY PARENT AND AUTHORIZED HEALTHCARE PROVIDER

AUTHORIZATION	Prescriber's Signature: _____ Prescriber's Authorization to Self- Administer <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Confirms student is capable to safely and properly administer medication</i>	Date: PRESCRIBER'S PRINTED NAME OR STAMP
	Parent: I hereby request that the above ordered medication be administered by school personnel and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. This protocol will be in effect until the end of the current or extended school year. This medication will be destroyed if not picked up within one week following termination of the order or the end of the school year. Whichever comes first, unless the student will be attending an extended school year (ESY) program. A new protocol will be needed for the next school year. I have received, reviewed and understand the above information.	
	Parent's Signature: _____ Parent's Authorization to Self- Administer <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:

TURN OVER FORM FOR INSTRUCTIONS ON ADMINISTERING EPINEPHRINE

EMERGENCY CARE PLAN FOR STUDENT

NAME: _____ GRADE/SCHOOL: _____

SYMPTOMS OF ANAPHYLAXIS:

- Chest tightness, shortness of breath, cough, wheezing, profuse runny nose
- Dizzy, faint, pale, blue, confused
- Tightness and/or itching in throat, difficulty swallowing, hoarseness, drooling
- Swelling of lips, tongue, throat
- Itchy mouth, itchy skin, hives
- Hives, itching (anywhere), swelling (eg face, eyes)
- Nausea, vomiting, diarrhea, crampy pain

Insert Picture if available

IF ALLERGEN LIKELY EATEN (OR STUDENT STUNG), FOLLOW THIS EPINEPHRINE PROTOCOL AT THE ONSET OF ANY OF THE ABOVE SYMPTOMS:

1. Administer Epi Auto-Injector: circle one: (0.15mg 0.3mg)
2. Have someone call 911 for ambulance, don't hang up, and stay with student
3. Administer Benadryl: circle one 12.5mg 25mg 37.5mg 50mg other _____
4. Have student lie down with feet above level of head until EMS arrives
5. Notify school and parent/guardian as soon as possible

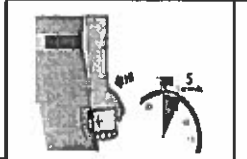
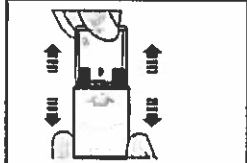
EPI AUTO-INJECTOR DIRECTIONS:

For EPIPEN and EPIPEN JR.:

1. Pull off blue activation cap.
2. Hold orange tip near outer thigh (always apply to thigh). Okay to inject through clothing.
3. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10; remove and massage 10 sec. Auto-Injector should then be removed and take to Emergency Room.

For Auvi-Q:

1. Follow verbal instructions.
2. Pull off red safety guard. Pull firmly to remove.
3. Place black end against middle of outer thigh (through clothing if needed.) Then press firmly and hold in place for 5 seconds.



EMERGENCY CONTACTS

1. Name:
Relation:
Phone:

2. Name:
Relation:
Phone:

EMERGENCY/PHYSICIAN CONTACTS

1. Name:
Relation:
Phone:

2. Name:
Relation:
Phone: