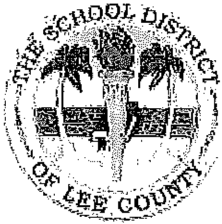

SEVERE ALLERGY AND ANAPHYLAXIS EMERGENCY CARE PLAN

School Year ______________ **Student's weight:** ______________

Student Name: ______________ **D.O.B.** ______________

Allergy type(s) ☐ Food ☐ Insect ☐ Medication ☐ Environmental

Allergic to : ______________

☐ **Check if Student has Asthma (higher risk for severe reaction)**

Parent or guardian name/signature: ______________ (Print name) ______________ (sign) **Phone:** ______________

Mild Symptoms

☐ If checked, give epinephrine immediately for **ANY** symptoms if the student was possibly exposed to the allergen.

MOUTH - Itchy mouth
NOSE - Itchy/Runny Nose, Sneezing
SKIN - A few hives, mild itch
Stomach - Mild nausea/discomfort

1. Give Antihistamines, if ordered by physician.
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

Severe Symptoms

NOTE: Do not depend on antihistamine or inhalers to treat a severe reaction. **Use epinephrine.**

☐ If checked, give epinephrine immediately if the student was definitely exposed to the allergen, even if there are no symptoms.

MOUTH - Itchy mouth,swelling of tongue/lips
Throat - Tight, hoarse, trouble breathing/swallow
SKIN - Many hives over a body, widespread redness
Stomach - Repetitive vomiting/severe diarrhea
LUNG - Short of breath, wheezing repetitive cough
HEART - Pale, blue, faint, week pulse, dizzy
OTHER - Feeling of impending doom, anxiety, confusion, or combination of mild or severe symptoms from different body areas

1. Inject Epinephrine immediately!
2. Call 911. Request ambulance with epinephrine:
*Consider giving additional medications (following or with the epinephrine):
>Antihistamine
>Inhaler (bronchodilator) if asthma
*Lay student flat and raise legs.
*If breathing is difficult, or they are vomiting, let them sit up or lie on their side.
*Alert Emergency contacts.
*Transport student to ER even if symptoms resolve.
*Student should remain in ER for 4+ hours because symptoms may return.

Medication Orders

Epinephrine Brand/type ☐ **Epipen 0.3 mg IM** ☐ **Epipen Jr 0.15 mg IM** ☐ **Auvi Q 0.3 mg IM** ☐ **Auvi Q 0.15 mg IM**

☐ **If checked- repeat dosing if symptoms worsen, or do not improve after 5 minutes of initial dose.**

☐ Check box if generic substitute is not allowed. Must complete Authorization to Carry and Self Administer form to carry EpiPen.

Medication	Dose	Route	Frequency	Comments:

Authorization to Carry and Self-Administer Medication

Authorization to Carry and Self-Administer Epinephrine Auto-Injector - Must be completed by Health Care Provider

Student may carry and self-administer Epinephrine Auto-Injector ○ Yes ○ No If yes, must complete the following:

☐ Student instructed on and verbalized understanding of the name, purpose, dose of medication.

☐ Student instructed on disease process of anaphylaxis and verbalized understanding of when to take medication.

☐ Student instructed on and verbalized understanding of his/her responsibility in carrying medication(s) and agrees not to share

☐ Student demonstrated correct use/administration of medication.

I, the student, understand that I am responsible and accountable for using and carrying the above medication as prescribed. I also understand that if there is irresponsible behavior or a safety risk the privilege of carrying the above medication will be rescinded.

Student's Signature ______________ Date ______________

LHC Provider Name/Signature: ______________ **Date:** ______________

LHC Provider Office Number: ______________ **LHC Provider Fax:** ______________

Nurse's Signature: ______________ **Date:** ______________