FOOD/INSECT & EMERGENCY ALLERGY ACTION PLAN and MEDICATION AUTHORIZATION

School District / School Name _____ Date _____

www.foodallergy.org

Student Name	Date of Birth	Student #
*Health Care Provider Name/Title	Provider's Office Phone / FAX #	
Parent/Guardian	Parent's Phone #s	
Emergency Contact	Contact Phone #s	

Place student's picture here

Known Life-Threatening Allergies:

Diagnosis of Mild Allergy? ☐ No ☐ Yes

Please list allergens:

History of Asthma? ☐ No ☐ Yes

(*Asthma may indicate an increased risk of severe reaction*)

History of SEVERE Anaphylactic Reaction? ☐ No ☐ Yes,

If checked **YES**, give epinephrine immediately!
Give epinephrine if allergen was ***likely*** eaten, at onset of ***any*** symptoms or if allergen was **definitely** eaten even if **no** symptoms are noticed.

TREATMENT PLAN

FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:

LUNG:	Difficulty breathing or swallowing, wheezing, coughing
HEART:	Dizzy, faint, confused, pale, blue, weak pulse
THROAT:	Tight, hoarse, trouble breathing/swallowing, drooling
MOUTH:	Significant swelling of tongue, lips
SKIN:	Many hives over body, widespread redness over body
GUT:	Nausea, repetitive vomiting, severe diarrhea, cramping
Other:	Feeling something bad is about to happen, anxiety, confusion

FOLLOW THIS PROTOCOL:

1. **INJECT EPINEPHRINE IMMEDIATELY!** (Note time)
2. **Call 911.** Request ambulance with epinephrine.
3. Don't hang up & don't leave student
4. Give additional medications as ordered
   - Antihistamine (if ordered below)
   - Inhaler (Albuterol) if student has asthma
5. Lay student flat and raise legs. If breathing is difficult or vomiting, sit up or lie on their side
6. Notify School Nurse and Parent/Guardian
7. Notify Prescribing Provider / PCP
8. Student must be transported to ER

☐ MILD ALLERGY SYMPTOMS (IF DIAGNOSIS CONFIRMED ABOVE):

MOUTH:	Itchy mouth, lips, tongue and/or throat
SKIN:	Itchy mouth
NOSE:	Itchy/runny nose
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE** as directed
2. Monitor student; alert emergency contacts
3. Watch student closely for changes
4. **If symptoms worsen, GO TO EPINEPHRINE PROTOCOL (see above)**

➢ THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL SYMPTOMS OF ANAPHYLAXIS CAN POTENTIALLY PROGRESS TO A LIFE THREATENING SITUATION!!

MEDICATION ORDER

Epinephrine

Student's weight _____ lbs.

☐ **Epinephrine (0.15mg)** inject intramuscularly — Epi Pen Auvi Q Adrenaclick

☐ **Epinephrine (0.3mg)** inject intramuscularly — Epi Pen Auvi Q Adrenaclick

A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.

Antihistamine

Do not depend on antihistamines (or inhalers). ***When in doubt, give epinephrine and call 911.***

☐ Benadryl/Diphenhydramine
Dose:
Route: PO
Frequency:

☐ Other _____
Dose:
Route:

SIDE EFFECTS OF EPINEPHRINE MAY INCLUDE:
ANXIETY, TREMOR, PALPITATIONS, DIZZINESS, WEAKNESS, TINGLING, & PALENESS

NOTE: IF NURSE IS NOT AVAILABLE, THE ABOVE TREATMENT PLAN MAY BE PROVIDED BY TRAINED SCHOOL PERSONNEL FOR ANY ANAPHYLAXIS SYMPTOMS.

MUST BE COMPLETED BY HEALTHCARE PROVIDER, PARENT, AND SCHOOL NURSE

AUTHORIZATION

*Prescriber's Signature: _____ Date: _____

Printed Name: _____ Phone: _____

I confirm student is capable to safely carry and properly administer above medication ☐ Yes ☐ No

Parent/Guardian Consent: I have received, reviewed and understand the above information. I approve of this Allergy Action Plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary. I assume full responsibility for providing the school with the prescribed medications. I give my permission for the school to share the above information with school staff that need to know about my child's condition.

Parent/Guardian Signature: _____ Date: _____

I confirm my child is capable to safely carry and properly administer above medication ☐ Yes ☐ No

School Nurse:

I have reviewed this order and completed the allergy emergency care plan and shared with trained school personnel.

_____
Signature / Date

Medication Expires on:

_____

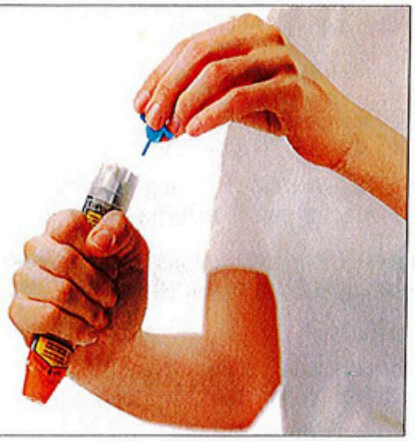
Blue to the sky. Orange to the thigh.

How to use EpiPen® and EpiPen Jr® (epinephrine) Auto-Injectors

Remove the EpiPen® Auto-Injector from the carrier tube and follow these 2 simple steps:

1

Blue to the sky



- Grasp with orange tip pointing downward
- Remove blue safety cap by pulling straight up – do not bend or twist

2

Orange to the thigh

- Place the orange tip against the middle of the outer thigh
- Swing and push the auto-injector firmly into the thigh until it "clicks"
- Hold in place for 3 full seconds

Built-in needle protection

After injection, the orange cover automatically extends to ensure the needle is never exposed.

After using EpiPen®, you must seek immediate medical attention or go to the emergency room. For the next 48 hours, you must stay close to a healthcare facility or be able to call 911.

EpiPen® and EpiPen Jr® (epinephrine) Auto-Injectors are indicated for the emergency treatment of anaphylactic reactions in patients who are determined to be at increased risk for anaphylaxis, including individuals with a history of anaphylactic reactions. Selection of the appropriate dosage strength is determined according to patient body weight.

EpiPen® and EpiPen Jr® Auto-Injectors are designed as emergency supportive therapy only. They are not a replacement for subsequent medical or hospital care. After administration, patients should seek medical attention immediately or go to the emergency room. For the next 48 hours, patients must stay within close proximity to a healthcare facility or where they can call 911. To ensure this product is right for you, always read and follow the label. Please consult the Consumer Information leaflet in your product package for warnings and precautions, side effects, and complete dosing and administration instructions.

Pfizer

REVIEWED BY PAAB

EPIPEN® (Epinephrine) Auto-Injectors 0.3/0.15mg

Trusted for over 35 years.