Emergency Action Plan for Allergy/Anaphylaxis

Student Name: ______________________________**DOB:** __________ **School:** ___________________________**Grade** _____

Parent/Guardian: ____**Phone:** ____________________________________

Emergency Contact: ____**Phone:** ____________________________________

TO BE COMPLETED BY HEALTH CARE PROVIDER

Student has allergy to:

Student has asthma: □Yes (higher risk for a severe reaction) □No

Epinephrine: Inject intramuscular using auto injector: (type) _______________________Dose: □0.15mg □0.3mg

Student may carry and self-administer □Yes (if unable, an adult must administer) □No

Antihistamine, by mouth (type, dose):____

	IF YOU SEE THIS	**DO THIS**
GREEN ZONE: COMPLETE AVOIDANCE OF ALLERGEN(S):	No symptoms	➢ No Treatment Necessary ➢ If allergen is food related continue to keep student from coming into contact and/or ingesting food product ➢ If allergen is Insect/Environmental related make every attempt to avoid exposure
YELLOW ZONE: MILD SYMPTOMS	NOSE: Itchy, runny nose, sneezing SKIN: A few hives, mild itch GUT: Mild nausea/discomfort	➢ Stay with student ➢ Monitor for worsening of symptoms ➢ Notify Parent ➢ Give antihistamine (if prescribed above) ➢ If two or more mild symptoms are present or symptoms progress: **GIVE EPINEPHRINE & CALL 911**
RED ZONE: SEVERE SYMPTOMS EMERGENCY	LUNG: Short of breath, wheeze, repetitive cough THROAT: Tight, hoarse, trouble breathing/swallowing MOUTH: Swelling of the tongue and/or lips HEART: Pale, blue, faint, weak pulse, dizzy SKIN: Many hives over body, widespread redness GUT: Repetitive vomiting, severe diarrhea OTHER: Feeling something bad is about to happen, confusion, agitation	➢ **INJECT EPINEPHRINE IMMEDIATELY** ➢ **CALL 911** • TELL EMERGENCY DISPATCHER THE STUDENT IS HAVING ANAPHYLAXIS AND ADDITIONAL EPINEPHRINE MAY BE NEEDED WHEN EMERGENCY RESPONDERS ARRIVE ➢ Stay with the student ➢ Keep them lying down, if vomiting or difficulty breathing lay on side ➢ Notify Parent

Please include any additional information/interventions related to allergies to ensure the student's needs are being met during the school day:____.

This order remains in effect for the current academic year only and must be renewed each school year. The administration of this medication/treatment to the student during the school day is necessary to maintain and support the student's continued presence in school.

____________________________________ ________ ____

Health Care Provider Signature **Date** **Phone Number/Office Stamp**

Parent Permission

I hereby give my permission for my child ______________________________________ to receive medication/treatment during school hours. This medication/treatment has been ordered and prescribed by a licensed physician. I hereby grant permission for the school nurse to communicate with the prescribing physician about the medication/treatment prescribed. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication/treatment. This consent is good for one year, and may be revoked at any time.

I will furnish all medications for use at school in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, the time/frequency it is to be given or taken, the route of administration, the number of doses in the container, and the expiration date of the medication). All over the counter medications will include the order for administration (first part of this authorization form signed by the doctor) with the identifying information, (name of child, medication dispensed, dosage prescribed according to label, and the time it is to be give or taken), with the medication in the original container.

I will replace this medication when it expires. I will remove this medication from the school the last day of school. I understand medication not picked up will be destroyed after the last day of school.

Parent or Guardian Signature: ____

Telephone number(s): ____

Emergency contact number in case you cannot be reached: ___________________________________

Student Competence Checklist with Nurse for Self-Administered Medication

□ I have verbalized the name of my medication, informed the nurse of how it is prescribed, and demonstrated competency in using this medication.

□ I will use this medication (and any accompanying equipment) only as directed by my health care practitioner.

□ I will not share my medication with anyone. Sharing medication or using it other than prescribed will result in disciplinary action.

□ I will notify a teacher or staff member if I am having difficulty or need to see the nurse.

□ I will keep my medication with me at all times while in school—location_____________________

________________________________ ____________________________________ _________________
Signature of Student Signature of Nurse (or trained personnel) Date