# FOOD/INSECT EMERGENCY ANAPHYLAXIS 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.

**School:** **Date:**

## STUDENT INFORMATION

| | |
|---|---|
| **Student Name** | **DOB:** |
| **Home/Cell Phone** | **Grade** |

**KNOWN LIFE-THREATENING ALLERGIES:** ☐ **PEANUTS** ☐ **TREE NUTS** ☐ **MILK** ☐ **SOY** ☐ **WHEAT** ☐ **SHELLFISH** ☐ **FISH (OTHER)** ☐ **BEE STINGS** ☐ **LATEX** ☐ **EGGS:**________________ ☐ **OTHER:**

**CONFIRMED WITH ALLERGY TESTING** ☐ **YES** ☐ **NO**

**KNOWN ORAL ALLERGY SYNDROME:** ☐ **No** ☐ **Yes (list):**

- Provide separate medication authorization if treatment indicated

**History of Asthma?** ☐ No ☐ Yes
(Increases risk of severe reaction)

**Severe Anaphylactic Reaction?** ☐ **Yes,**
☐ This child has an extreme severe allergy. Give Epinephrine immediately if allergen was ***likely*** eaten, at onset of ***any*** symptoms and follow the protocol below.

## TREATMENT PLAN

**AFTER EXPOSURE TO KNOWN OR SUSPECTED ALLERGY & ANY OF THESE SYMPTOMS:**

**AIRWAY:** Difficulty breathing, swallowing, chest tightness, wheeze
**THROAT:** Tight, hoarse, swollen tongue, difficulty swallowing/drooling
**CARDIAC:** Dizzy, faint, confused, pale or blue, hypotension, weak pulse

**&/OR**

**ANY COMBINATION OF SYMPTOMS FROM DIFFERENT BODY AREAS:**
- Swollen lips, repetitive cough, sneezing, profuse runny nose
- Hives, itching (anywhere), swelling (e.g., eyes)
- Nausea, Vomiting, diarrhea, crampy pain

**FOLLOW THIS PROTOCOL:**

1. **INJECT EPINEPHRINE IMMEDIATELY!**
2. Call 911
3. Lie down if able, avoid rapid upright positioning & 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 very slowly.

## EPINEPHRINE

☐ Epinephrine Auto-injector, Jr (0.15mg) IM side of thigh ☐ Epinephrine Auto-injector (0.3mg) IM side of thigh

- **A second dose** of epinephrine can be given 5 minutes or more if symptoms persist or recur.

**Relevant Side Effects** ☐ Tachycardia ☐ Other: **Medication Allergies** ☐ NKDA ☐ Other:

**Medication shall be administered during school year:** **TO**

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

## TO BE COMPLETED BY PARENT AND AUTHORIZED HEALTHCARE PROVIDER: REQUIRED

## AUTHORIZATION

- *Confirms student is capable of carrying medication* ☐ **Yes** ☐ **No**
- *Confirms student is capable to safely and properly administer medication* ☐ **Yes** ☐ **No**

**If a child refuses/is unable to self-treat, a trained personnel must be available and able to administer medication**

**Prescriber's Signature:** **Date**

**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:** **Date**

## EMERGENCY CARE PLAN FOR STUDENT

**NAME:** **SCHOOL/GRADE/TEACHER:** **DATE:**
**ALLERGY:** **DATE OF BIRTH:**

**SYMPTOMS OF ANAPHYLAXIS:**

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

Insert picture here

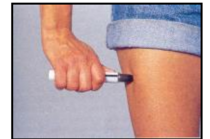
**IF ALLERGEN LIKELY EATEN (OR STUDENT STUNG), FOLLOW THIS EPINEPHRINE PROTOCOL AT THE ONSET OF ANY OF THE ABOVE SYMPTOMS:**

1. Administer Epi Auto-Injector: _______**0.15mg** _______**0.3mg**.
2. Have someone call 911 for ambulance, don't hang up, and stay with student.
3. Administer Benadryl: _____ **tablet(s),** _______ **tsp. liquid,** ______**No Benadryl ordered**.
4. Administer albuterol if authorized (has asthma).
5. Have student lie down, if able, with feet above level of head until EMS arrives.
6. Notify school and parent/guardian as soon as possible.

**EPI AUTO-INJECTOR DIRECTIONS:**

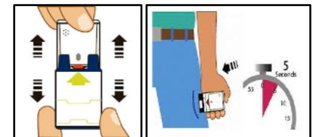
☐ **For EPIPEN and EPIPEN JR.:**

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 3. Massage injection area for 10 seconds.
4. Auto-Injector should then be removed and taken with you to Emergency Room.



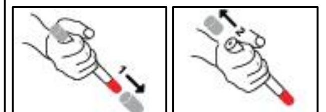
☐ **For Auvi-Q:**

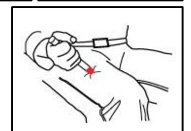
1. Follow verbal instructions.
2. Pull off red safety guard. Pull firmly to remove.
3. Place black end against middle of outer thigh (through clothing if needed.) Then press firmly and hold in place for 5 seconds. Take the Auto Injector to the Emergency Room.



☐ **For Generic Epinephrine Auto-Injector:**

1. TWIST and pull off outside container.
2. Pull off BOTH end caps.
3. Hold red tip against middle of outer thigh. OK to inject through clothing.
4. Press down hard until needle enters the thigh. Hold in place for 10 seconds.
5. Check red tip. If needle is exposed, medication has been received. If needle is not visible, repeat steps 3 and 4.
6. CAREFULLY place injector back into outside container, needle tip first. Take the container to the Emergency Room.





**EMERGENCY CONTACTS**

1. Name & Relation:
   Phone: Cell:
2. Name & Relation:
   Phone: Cell:

**EMERGENCY/PHYSICIAN CONTACTS**

1. Name & Relation:
   Phone: Cell:
2. Name & Relation:
   Phone: Cell:

______________________ ______________________ ______________________

**Parent** **Student** (if applicable) **School Nurse**