Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

Student's Name: _____D.O.B. _____ Grade: _____
School: _____ Teacher: _____
ALLERGY TO: _____
HISTORY:_____
_____
Asthma: ☐ YES (higher risk for severe reaction) ☐ NO

Place child's photo here

To be completed by healthcare provider

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy,
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Significant swelling of the tongue and/or lips
SKIN: Many hives over body, widespread redness
GUT: Repetitive vomiting, severe diarrhea
OTHER: Feeling something bad is about to happen, confusion

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1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911 and activate school emergency response team
3. Call parent/guardian and school nurse
4. Monitor student; keep them lying down
5. Administer Inhaler (quick relief) if ordered
6. Be prepared to administer 2nd dose of epinephrine if needed

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe food related reaction . **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:
NOSE: Itchy, runny nose, sneezing
SKIN: A few hives, mild itch
GUT: Mild nausea/discomfort

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1. Alert parent and school nurse
2. Antihistamines may be given if ordered by a healthcare provider,
3. Continue to observe student
4. If symptoms progress **USE EPINEPHRINE**
5. Follow directions in above box

DOSAGE: **Epinephrine**: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve ____minutes or more, or symptoms return, 2nd dose of epinephrine should be given

Antihistamine: (brand and dose)_____

Asthma Rescue Inhaler: (brand and dose)_____

Student has been instructed and is capable of carrying and self-administering own medication. ☐ Yes ☐ No

Provider (print) _____Phone Number: _____

Provider's Signature: _____ Date: _____

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: _____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. _____1) _____ 2) _____
   b. _____ 1) _____ 2) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

Student Name: _____ **DOB:** _____

1._____ Room _____

2._____ Room _____

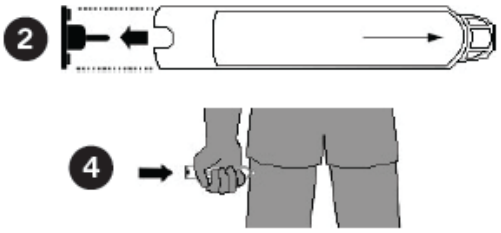
3._____ Room _____

Self-carry contract on file: ☐Yes ☐No

Expiration date of epinephrine auto injector: _____

EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Firmly push orange tip against outer thigh.
4. Hold for approximately 3 seconds.
5. Remove and massage area for 10 seconds.



ADRENACLICK™/ADRENACLICK™ GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled “1” and “2”.
3. Place red rounded tip against outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

NOTE: Consider lying on the back with legs elevated. Alternative positioning may be needed for vomiting (side lying, head to side) or difficulty breathing (sitting)

Additional information:_____

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