

NM FOOD/INSECT & EMERGENCY ALLERGY ACTION PLAN and MEDICATION AUTHORIZATION

School District / School Name _____ Date _____

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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

<p>Known Life-Threatening Allergies:</p> <p>Diagnosis of Mild Allergy? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Please list allergens:</p>	<p>History of Asthma? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(Asthma may indicate an increased risk of severe reaction)</i></p> <hr/> <p>History of SEVERE Anaphylactic Reaction? <input type="checkbox"/> No <input type="checkbox"/> 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.</p>
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TREATMENT PLAN	<p>FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:</p> <p>LUNG: Difficulty breathing or swallowing, wheezing, coughing</p> <p>HEART: Dizzy, faint, confused, pale, blue, weak pulse</p> <p>THROAT: Tight, hoarse, trouble breathing/swallowing, drooling</p> <p>MOUTH: Significant swelling of tongue, lips</p> <p>SKIN: Many hives over body, widespread redness over body</p> <p>GUT: Nausea, repetitive vomiting, severe diarrhea, cramping</p> <p>Other: Feeling something bad is about to happen, anxiety, confusion</p>	<p>FOLLOW THIS PROTOCOL:</p> <ol style="list-style-type: none"> 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 <ul style="list-style-type: none"> • 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
	<p><input type="checkbox"/> MILD ALLERGY SYMPTOMS (IF DIAGNOSIS CONFIRMED ABOVE):</p> <p>MOUTH: Itchy mouth, lips, tongue and/or throat</p> <p>SKIN: Itchy mouth</p> <p>NOSE: Itchy/runny nose</p> <p>GUT: Mild nausea/discomfort</p>	<ol style="list-style-type: none"> 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	<p>Epinephrine</p> <p>Student's weight _____ lbs.</p>	<p><input type="checkbox"/> Epinephrine (0.15mg) inject intramuscularly Epi Pen Auvi Q Adrenaclick</p>	<p><input type="checkbox"/> Epinephrine (0.3mg) inject intramuscularly Epi Pen Auvi Q Adrenaclick</p>	
	<p>A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.</p>			
	<p>Antihistamine Do not depend on antihistamines (or inhalers). <i>When in doubt, give epinephrine and call 911.</i></p>	<p><input type="checkbox"/> Benadryl/Diphenhydramine Dose: _____ Route: PO Frequency: _____</p>	<p><input type="checkbox"/> Other _____ Dose: _____ Route: _____</p>	<p>SIDE EFFECTS OF EPINEPHRINE MAY INCLUDE: ANXIETY, TREMOR, PALPITATIONS, DIZZINESS, WEAKNESS, TINGLING, & PALENESS</p>
<p>NOTE: IF NURSE IS NOT AVAILABLE, THE ABOVE TREATMENT PLAN MAY BE PROVIDED BY TRAINED SCHOOL PERSONNEL FOR ANY ANAPHYLAXIS SYMPTOMS.</p>				

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

AUTHORIZATION	<p>*Prescriber's Signature: _____ Date: _____</p> <p>Printed Name: _____ Phone: _____</p> <p><i>I confirm student is capable to safely carry and properly administer above medication</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>School Nurse:</p> <p>I have reviewed this order and completed the allergy emergency care plan and shared with trained school personnel.</p>
	<p>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.</p>	<p>_____ Signature / Date</p>
	<p>Parent/Guardian Signature: _____ Date: _____</p> <p><i>I confirm my child is capable to safely carry and properly administer above medication</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Medication Expires on: _____</p>