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

**School District / School Name** _____ **Date** _____ **School Year** _____

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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 | |

**Epinephrine injector is stored in:**

☐ With Student
☐ Classroom
☐ Health Office
☐ _____

**Student's weight:** _____**lbs.**

**Asthma:** ☐ **YES (higher risk for a severe reaction)** ☐ **No**

**Allergy to:**

**Give epinephrine immediately:**

**[ ] for ANY symptoms if allergen was likely eaten.**

**[ ] If allergen was definitely eaten, even if no symptoms are noticed.**

## TREATMENT PLAN

**FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:**

**LUNG:** Short of breath, wheezing, repetitive cough

**HEART:** Dizzy, faint, confused, pale, blue, weak pulse

**THROAT:** Tight, hoarse, trouble breathing/swallowing, drooling

**MOUTH:** 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

**OR A combination of mild symptoms from different body areas**

**FOLLOW THIS PROTOCOL:**

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

**MILD ALLERGY SYMPTOMS:**

**MOUTH:** Itchy mouth, lips, tongue and/or throat
**SKIN:** A few hives, itchy skin
**NOSE:** Itchy/runny nose, sneezing
**GUT:** Mild nausea/discomfort

1. GIVE ANTIHISTAMINE (as ordered below)
2. Stay with student; alert school nurse & parent/guardian
3. Watch student closely for changes
   - If symptoms worsen, **GIVE EPINEPHRINE**
   - For mild symptoms from more than one body area - **GIVE EPINEPRHINE** (see above).

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

## MEDICATION ORDER

**Epinephrine**

☐ **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: _____mg.
Route: PO

☐Other _____
Dose: _____mg
Route:

Note: If School Nurse is not available, the above treatment plan may be provided by trained school personnel for any anaphylaxis symptoms.

**MUST BE COMPLETED BY PARENT AND AUTHORIZED HEALTH CARE PROVIDER**

## AUTHORIZATION

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

**Printed Name:** _____ **Phone:** _____

*Student is able to carry and self-administer his/her medication at school* ☐ 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 carry and administer above medication* ☐ Yes ☐ No

**School Nurse:**

I have reviewed this order and completed the Allergy Emergency Care Plan and have trained school personnel.

_____
***Signature / Date***

**Medication Expires on:**

_____