EMERGENCY CARE PLAN FOR STUDENT

NAME: ____________________________  GRADE/SCHOOL: ____________________________

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

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: circle one: (0.15mg  0.3mg)
2. Have someone call 911 for ambulance, don’t hang up, and stay with student
3. Administer Benadryl: circle one 12.5mg  25mg  37.5mg  50mg  other________
4. Have student lie down with feet above level of head until EMS arrives
5. Notify school and parent/guardian as soon as possible

EPI AUTO-INJECTOR DIRECTIONS:

☐ For EPI PEN and EPI PEN 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 10; remove and massage 10 sec.
   Auto-Injector should be taken to Emergency Room with student.

☐ 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.

EMERGENCY CONTACTS

1. Name: ____________________________  Relation: ____________________________  Phone: ____________________________
2. Name: ____________________________  Relation: ____________________________  Phone: ____________________________

EMERGENCY/PHYSICIAN CONTACTS

1. Name: ____________________________  Relation: ____________________________  Phone: ____________________________
2. Name: ____________________________  Relation: ____________________________  Phone: ____________________________
FOOD/INSECT & EMERGENCY ALLERGY CARE PLAN and MEDICATION AUTHORIZATION

Connecticut State Law and Regulations 10-212(e) 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.

<table>
<thead>
<tr>
<th>Student Name</th>
<th>DOB:</th>
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<tr>
<td>Home/Cell Phone</td>
<td>Grade</td>
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**Known Life-Threatening Allergies:**

- History of Asthma? [ ] No [ ] Yes
  - (Asthma may indicate an increased risk of severe reaction)

- History of SEVERE Anaphylactic Reaction? [ ] No [ ] Yes
  - If checked YES, give epinephrine immediately if allergen was likely eaten, at onset of any symptoms, and follow the protocol below

**Diagnosis of Oral Allergy Syndrome? [ ] No [ ] Yes**

Please list OAS allergens:

**TREATMENT PLAN**

ANY ONE OF THESE SEVERE SYMPTOMS OF ANAPHYLAXIS AFTER SUSPECTED OR KNOWN INGESTION:

- Difficulty breathing or swallowing
- Dizzy, faint, confused, pale or blue, hypotension/weak pulse

ANY COMBINATION OF SYMPTOMS FROM DIFFERENT BODY AREAS:

- AIRWAY: Short of breath, chest tightness, wheeze, repetitive cough, profuse runny nose
- THROAT: Tight, hoarse, trouble breathing/swallowing, drooling
- MOUTH: Swollen lips or tongue
- SKIN: Hives, itch rash, swelling (e.g., eyes, lips)
- GUT: Nausea, Vomiting, diarrhea, crampy pain

ORAL ALLERGY SYNDROME (IF DIAGNOSIS CONFIRMED ABOVE):

- MOUTH: Itchy mouth, lips, tongue and/or throat
- SKIN: Itching just around mouth

THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL SYMPTOMS OF ANAPHYLAXIS CAN POTENTIALLY PROGRESS TO A LIFE-ThREATENING SITUATION.

- Epinephrine [ ] Epi Auto-injector, Jr (0.15mg) inject intramuscularly [ ] Epi Auto-injector (0.3mg) inject intramuscularly
  - A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.

- Antihistamine [ ] Benadryl/Diphenhydramine
  - Dose:
  - Route: PO
  - Frequency:

FOLLOW THIS PROTOCOL:

1. INJECT EPINEPHRINE IMMEDIATELY!
2. Call 911
3. Raise feet above the head, remain lying down & 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 slowly.

- 1. GIVE ANTIHISTAMINE (swish, gargle, &swallow)
2. Monitor student as indicated; notify healthcare provider & parent as indicated
3. If progresses to symptoms of anaphylaxis, USE EPINEPHRINE (as stated above)

**DOSEAGE OF MEDICATIONS**

- Medication shall be administered during school year: 2013 to 2014

**TO BE COMPLETED BY PARENT AND AUTHORIZED HEALTHCARE PROVIDER**

<table>
<thead>
<tr>
<th>Prescriber's Signature:</th>
<th>Prescriber's Authorization to Self Administer</th>
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<tbody>
<tr>
<td>Date:</td>
<td>PRESCRIBER'S PRINTED NAME OR STAMP</td>
</tr>
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**CONFIRMS student is capable to safely and properly administer medication [ ] Yes [ ] No**

**AUTHORIZATION**

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: [ ] Yes [ ] No

**DATE:**

School Health Services, Rev. 4/13