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) – refer to their asthma care plan

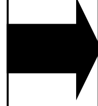
☐ NO

◊ STEP 1: TREATMENT

To be completed by healthcare provider

SEVERE SYMPTOMS: Any of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Swelling of the tongue and/or lips
- HEART: Pale, blue, faint, weak pulse, dizzy
- SKIN: Many hives over body, widespread redness
- GUT: Vomiting or diarrhea (if severe or combined with other symptoms
- OTHER: Feeling something bad is about to happen, Confusion, agitation

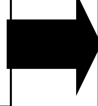


1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
   - Ask for ambulance with epinephrine
   - Tell EMS when epinephrine was given
3. Stay with child and
   - Call parent/guardian and school nurse
   - If symptoms don't improve or worsen give second dose of epi if available as instructed below
   - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinphrine. **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

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



1. Stay with child and
   - Alert parent and school nurse
   - Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and 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 if available

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: ________________________

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an anaphylactic 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) _________________

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 and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: ____ Date: ________________________

School Nurse: ____ Date: _________________________

Student Name: ____ **DOB:** ________________________________

Staff trained and delegated to administer emergency medications in this plan:

1.____ Room ___________________________

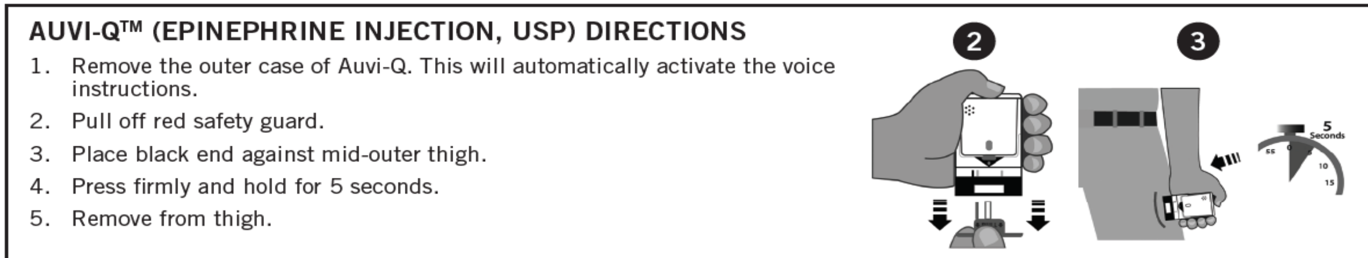
2.____ Room ___________________________

3.____ Room ___________________________

Self-carry contract on file: ☐Yes ☐No

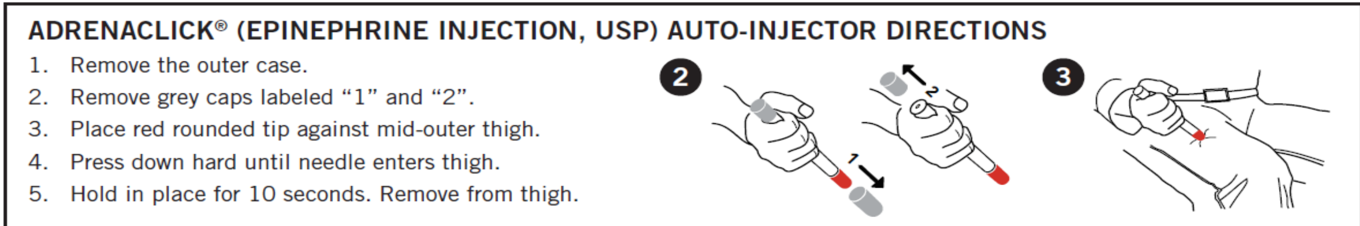
Expiration date of epinephrine auto injector: _________________________________

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.



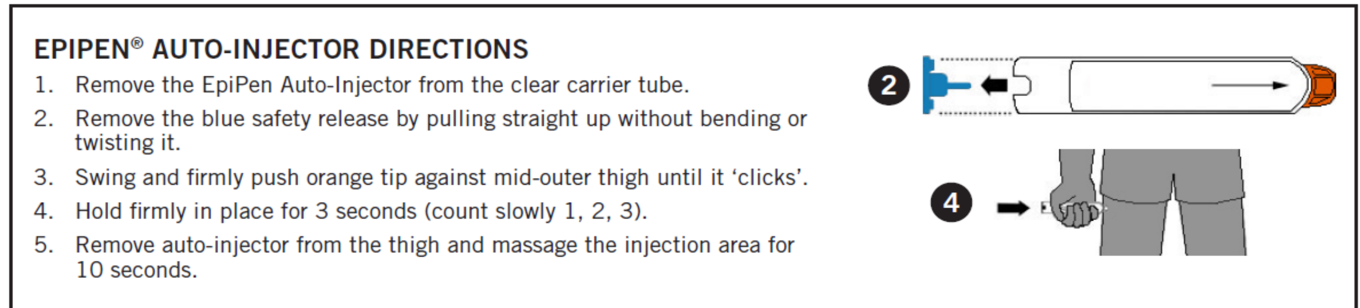
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

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



EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it ‘clicks’.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.

If this conditions warrents meal accomodations from food service, please complete the form for dietary disabilitiy if required by district policy.

Additional information:____

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Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017

COLORADO
Early Colleges
Parker

CONTRACT TO CARRY/SELF-ADMINISTER MEDICATION

This Contract is for students diagnosed with asthma, anaphylaxis, severe allergies, and/or other related life-threatening conditions and is in effect for the current school year unless revoked by a physician or if the Student fails to meet contingencies cited below.

Student Name ______________________________ **Date** ______________

School ______________________________ **DOB** ______________

Medication ______________________________ **Purpose of Medication** ______________

<u>Student:</u>

- I agree to keep my Medication with me at school and use it in a responsible manner as instructed by my above referenced health care provider.
- I will notify school office staff if my condition for which I am prescribed the Medication presents any unusual difficulty.
- I will notify the office staff if and when I use the Medication.
- I will not allow any other student to administer my Medication to him or herself and understand that if I do, I will be disciplined in accordance with the Douglas County School District Re.1's Student Code and understand that if I do, I will be appropriately disciplined in accordance with Douglas County School District Re.1's Student Code of Conduct and Discipline.
- I understand that if I fail to comply with this contract, my privilege to carry and self-administer the Medication may be withdrawn.

____

(Student Signature) (Date of Signature)

<u>Parent or Guardian:</u>

- I will assure that my child, the above-referenced Student, will carry his/her Medication as prescribed, and that the device containing the Medication and provided to the above-referenced school is appropriately labeled by a pharmacist or healthcare provider and contains Medication that has not expired.
- I will assure that backup Medication is provided to the health office staff at the above-referenced school for emergencies.
- I will review the attached health care plan on a regular basis with my child.

______________________________ ______________________________

(Parent/Guardian Signature) (Date of Signature)

<u>School Nurse:</u>

- I will assure that the Student can demonstrate the correct technique for self-administering the Medication.
- I will assure that the Student has an understanding of the above-references physician's order pertaining to proper time and dosages for self-administering the Medication.
- I agree to assure that appropriate school staff is made aware of the Student's condition and the need for the Student to carry the Medication.
- I agree to review on a regular basis with the Student, the status of the Student's asthma/allergy as identified above.
- I agree to assign a designee to make a 911 emergency call if and when the Student is exposed in such a way as to require his/her use of epinephrine (EpiPen)*

______________________________ ______________________________

(School Nurse Signature) (Date of Signature)

* Only applies to students who are prescribed epinephrine