

Allergy and anaphylaxis emergency action plan

Allergy and anaphylaxis Emergency action plan (EAP) Medication authorization and self-administration form In accordance with 26B-4-407 Utah Department of Health & Human Services/Utah State Board of Education			School year:	Picture
Student information				
Asthma: <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, high risk for severe reaction, please also complete asthma action plan)				
Student name:	Date of birth:	Grade:	School:	
Parent name:	Phone:	Email:		
Physician name:	Phone:	Fax or email:		
School nurse name:	School phone:	Fax or email:		
Medical diagnosis(es):	Age at diagnosis:	Confirmed by healthcare provider? <input type="radio"/> yes <input type="radio"/> no		
Allergen(s)				
Allergy to:				
<input type="checkbox"/> Give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms. <input type="checkbox"/> Give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.				
Yellow: mild to moderate reaction		Action		
Mild symptoms <ul style="list-style-type: none"> <li>Itchy or runny nose</li> <li>Itchy mouth</li> <li>A few hives (mild itch)</li> <li>Mild nausea or discomfort</li> </ul>		For <b>mild symptoms</b> from a <b>single system</b> area, follow the directions below: <ul style="list-style-type: none"> <li>Antihistamines may be given, if ordered by a healthcare provider.</li> <li>Stay with the person and alert emergency contacts.</li> <li>Watch closely for changes. If symptoms worsen, give epinephrine.</li> </ul> <p style="text-align: center; color: red;"><b>For more than one symptom, give epinephrine.</b></p>		
Red: severe reaction		Action		
Severe symptoms <ul style="list-style-type: none"> <li>Short of breath, wheezing, or repeated coughing</li> <li>Skin color is pale or blue</li> <li>Faint, weak pulse, or dizzy</li> <li>Tight or hoarse throat, trouble breathing or swallowing</li> <li>Significant swelling of the tongue or lips</li> <li>Many hives over the body, widespread redness</li> <li>Repetitive vomiting or severe diarrhea</li> <li>Feeling something bad is about to happen, anxiety, or confusion</li> </ul>		<ol style="list-style-type: none"> <li><b>1. Inject epinephrine immediately.</b></li> <li>2. Call EMS. Tell them the student is having anaphylaxis and may need epinephrine when they arrive.</li> <li>3. Lay the person flat, raise their legs, and keep them warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.</li> <li>4. Give a second dose of epinephrine if symptoms continue, get worse, or do not get better in 5 minutes.</li> <li>5. Alert the student's emergency contacts.</li> <li>6. Give other medication (only if prescribed). <b>DO NOT use other medication in place of epinephrine</b> (for example, do not give an antihistamine or inhaler instead of the epinephrine).</li> <li>7. Transport them to the emergency department even if their symptoms resolve. The person should remain in the emergency department for at least 4 hours because symptoms may return.</li> </ol>		
Medication				
Medication brand	Dose	Side effects		
Epinephrine:	<input type="checkbox"/> 0.15 mg IM <input type="checkbox"/> 0.3 mg IM			
Antihistamine:				
Other: (inhaler-bronchodilator of wheezing)				
CONTINUED ON NEXT PAGE				

Allergy and anaphylaxis emergency action plan

Student name:	Date of birth:	School year:
<b>Prescriber to complete</b>		
The above-named student is under my care with a medical diagnosis of _____.		
<b>The above reflects my plan of care for the above-named student.</b>		
<input type="checkbox"/> <b>It is</b> medically appropriate for the student to self-carry epinephrine auto injector (EAI) medication. The student should be in possession of EAI medication and supplies at all times. <ul style="list-style-type: none"> <li><input type="checkbox"/> Student can self-carry and self-administer EAI if needed, when able and appropriate.</li> <li><input type="checkbox"/> Student can self-carry, but not self-administer EAI.</li> </ul> <input type="checkbox"/> <b>It is not</b> medically appropriate for the student to carry and self-administer this EAI medication. The appropriate/designated school personnel should keep the student's medication for use in an emergency.		
<input type="checkbox"/> Additional orders:		
Prescriber name:	Phone:	
Prescriber signature:	Date:	
<b>Parent to complete</b>		
<ul style="list-style-type: none"> <li>• I am responsible to provide the epinephrine auto injector medication and bring it to the school. It must be in the current original pharmacy container and have a pharmacy label with the student's name, medication name, administration time, medication dosage, and healthcare provider's name.</li> <li>• I will deliver the medication to the school and replace the epinephrine auto injector medication within 2 weeks if the epinephrine auto injector single dose medication is given.</li> <li>• I will provide any changes to my child's prescription or dosing information to the school. I will complete an updated epinephrine auto injector medication authorization and self-administration form (this form) before the designated staff can administer the updated epinephrine auto injector medication prescription.</li> </ul>		
<b>Parent/guardian authorization</b>		
<input type="checkbox"/> I <b>give permission</b> for my student to carry the prescribed medication described above. My student is responsible for, and capable of, possessing an epinephrine auto-injector per UCA 26B-4-407. My student and I understand there are serious consequences for sharing any medication with others. <input type="checkbox"/> I <b>give permission</b> for my student to self-carry and self-administer EAI if needed, when able and appropriate. <input type="checkbox"/> I <b>give permission</b> for my student to self-carry, but not self-administer EAI. <input type="checkbox"/> I <b>do not give permission</b> for my student to carry and self-administer this medication. Only the appropriate/designated school personnel can keep my student's medication for use in an emergency.		
Parent signature:	Date:	
As the parent/guardian of the above-named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in this emergency action plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand, or action, etc., against them for helping my student with allergy/anaphylaxis treatment, provided the personnel are following prescriber instruction as written in the emergency action plan above. I am responsible for maintaining necessary supplies, medication, and equipment. I give permission for communication between the prescribing healthcare provider and the school nurse if necessary for allergy management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is my responsibility to notify school staff whenever there is any change in my student's health status or care.		
Parent name (print):	Signature:	Date:
Emergency contact name:	Relationship:	Phone:
<b>School nurse (or principal designee if no school nurse)</b>		
<input type="checkbox"/> Signed by prescriber and parent	<input type="checkbox"/> Medication is appropriately labeled	<input type="checkbox"/> Medication log generated
EAI is kept: <input type="checkbox"/> Student carries <input type="checkbox"/> Backpack <input type="checkbox"/> Classroom <input type="checkbox"/> Health office <input type="checkbox"/> Front office		
<input type="checkbox"/> Other (specify):		
Allergy and anaphylaxis EAP distributed to "need to know" staff: <input type="checkbox"/> Teacher(s) <input type="checkbox"/> PE teacher(s)		
<input type="checkbox"/> Transportation staff <input type="checkbox"/> Front office/admin staff <input type="checkbox"/> Other (specify):		
School nurse signature:	Date:	