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: ☐ No ☐ 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? ☐ yes ☐ no

Allergen(s)

Allergy to:

☐ Give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ Give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

☐ Give epinephrine immediately if:

Yellow: mild to moderate reaction	**Action**
Mild symptoms ● Itchy or runny nose ● Itchy mouth ● A few hives (mild itch) ● Mild nausea or discomfort	For mild symptoms from a single system area, follow the directions below: ● Antihistamines may be given, if ordered by a healthcare provider. ● Stay with the person and alert emergency contacts. ● Watch closely for changes. If symptoms worsen, give epinephrine. For more than one symptom, give epinephrine.
Red: severe reaction	**Action**
Severe symptoms ● Short of breath, wheezing, or repeated coughing ● Skin color is pale or blue ● Faint, weak pulse, or dizzy ● Tight or hoarse throat, trouble breathing or swallowing ● Significant swelling of the tongue or lips ● Many hives over the body, widespread redness ● Repetitive vomiting or severe diarrhea ● Feeling something bad is about to happen, anxiety, or confusion	1. Inject epinephrine immediately. 2. Call EMS. Tell them the student is having anaphylaxis and may need epinephrine when they arrive. 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. 4. Give a second dose of epinephrine if symptoms continue, get worse, or do not get better in 5 minutes. 5. Alert the student's emergency contacts. 6. Give other medication (only if prescribed). DO NOT use other medication in place of epinephrine (for example, do not give an antihistamine or inhaler instead of the epinephrine). 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.

Medication

Medication brand	**Dose**	**Side effects**
Epinephrine:	☐ 0.15 mg IM ☐ 0.3 mg IM	
Antihistamine:		
Other: (inhaler-bronchodilator of wheezing)		

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Allergy and anaphylaxis emergency action plan

Student name:	**Date of birth:**	**School year:**

Prescriber to complete

The above-named student is under my care with a medical diagnosis of _____.

The above reflects my plan of care for the above-named student.

☐ **It is** 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.

☐ Student can self-carry and self-administer EAI if needed, when able and appropriate.

☐ Student can self-carry, but not self-administer EAI.

☐ **It is not** 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.

☐ Additional orders:

Prescriber name:	Phone:
Prescriber signature:	Date:

Parent to complete

• 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.

• 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.

• I will provide any changes to my child's prescription or dosing information to the school. I will complete an updated epinephrine auto injector **m**edication authorization and self-administration form (this form) before the designated staff can administer the updated epinephrine auto injector medication prescription.

Parent/guardian authorization

☐ **I give permission** 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.

☐ **I give permission** for my student to self-carry and self-administer EAI if needed, when able and appropriate.

☐ **I give permission** for my student to self-carry, but not self-administer EAI.

☐ **I do not give permission** 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:

School nurse (or principal designee if no school nurse)

☐ Signed by prescriber and parent	☐ Medication is appropriately labeled	☐ Medication log generated

EAI is kept: ☐ Student carries ☐ Backpack ☐ Classroom ☐ Health office ☐ Front office
☐ Other (specify):

Allergy and anaphylaxis EAP distributed to "need to know" staff: ☐ Teacher(s) ☐ PE teacher(s)
☐ Transportation staff ☐ Front office/admin staff ☐Other (specify):

School nurse signature:	Date: