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) ☐ NO

Place child's photo here

To be completed by healthcare provider

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy,
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Significant swelling of the tongue and/or lips
SKIN: Many hives over body, widespread redness
GUT: Repetitive vomiting, severe diarrhea
OTHER: Feeling something bad is about to happen, confusion

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911 and activate school emergency response team
3. Call parent/guardian and school nurse
4. Monitor student; keep them lying down
5. Administer Inhaler (quick relief) if ordered
6. Be prepared to administer 2nd dose of epinephrine if needed

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe food related reaction . **USE EPINEPHRINE**

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

1. Alert parent and school nurse
2. Antihistamines may be given if ordered by a healthcare provider,
3. Continue to observe student
4. If symptoms progress **USE EPINEPHRINE**
5. 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

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: _____

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an allergic 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) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; 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. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____