EPIPEN + BENADRYL

Allergy and Anaphylaxis Action 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

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:
- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Obstructive swelling (tongue and/or lips)
- SKIN: Many hives over body

Or **combination** of symptoms from different body areas:
- SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
- GUT: Vomiting, crampy pain

→

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   - Antihistamine
   - Inhaler (quick relief) if asthma

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE

MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort

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1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

DOSAGE

Epinephrine: inject intramuscularly using autoinjector (check one): ☐ **0.3 mg** ☐ **0.15 mg**
☐ Administer 2nd dose if symptoms do not improve in _____minutes
Antihistamine: (brand and dose)_____
If Asthmatic: (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: _____

INHALERS

COLORADO SCHOOL ASTHMA CARE PLAN & MEDICATION ORDERS

Photo of child

Name:	Birth date:
Teacher:	Grade:
Parent/Guardian:	Cell Phone:
Home Phone:	Work Phone:
Other Contact:	Phone:
Preferred Hospital:	

Triggers: ☐ Weather (cold air, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐ Dog/Cat ☐ Dust ☐ Mold ☐ Pollen
Other:_____
Location of medication: ☐ school office ☐ student possession at all times ☐ other location (list)_____

GREEN ZONE: PRETREATMENT STEPS FOR EXERCISE (Health provider please complete section)

☐ Give 2 puffs of quick relief med *(name)* _____ 15 minutes before activity (Circle indication: Phys Ed class, exercise/sports, recess) Explanation:_____
☐ Repeat in 4 hours if needed for additional or ongoing physical activity

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA (Health provider complete dosing for quick relief med)

IF YOU SEE THIS:	DO THIS:
▪ Difficulty breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Unable to tolerate regular activities but still talking in complete sentences ▪ Other:	▪ Stop physical activity ▪ Give quick relief med *(name)*:_____ ☐ 2 puffs ☐ Via spacer ☐ With mask ☐ other:_____ ▪ If no improvement in 10-15 minutes, repeat use of rescue med: ☐ 2 puffs ☐ Via spacer ☐ With mask ☐ other:_____ ▪ If student's symptoms do not improve or worsen, call 911 ▪ Stay with student and maintain sitting position ▪ Call parents/guardians and school nurse ▪ Student may resume normal activities once feeling better

▪ If there is **no quick relief inhaler at school**:
➢ Call parents/guardians to pick up student and/or bring inhaler/ medications to school
➢ Inform them that if they cannot get to school, 911 may be called

RED ZONE: EMERGENCY SITUATION (Health provider complete dosing for quick relief med)

IF YOU SEE THIS:	DO THIS IMMEDIATELY:
▪ Coughs constantly ▪ Struggles or gasps for breath ▪ Trouble talking (can speak only 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness	▪ Give quick relief med *(name)*:_____ ☐ 2 puffs ☐ Via spacer ☐ With mask ☐ other:_____ ▪ Repeat quick relief med if student not improving in 10-15 minutes ☐ 2 puffs ☐ Via spacer ☐ With mask ☐ other:_____ ☐ Refer to anaphylaxis plan if student has life threatening allergy. ▪ Call 911 Inform attendant the reason for the call is asthma ▪ Call parents/guardians and school nurse ▪ Encourage student to take slower deeper breaths ▪ Stay with student and remain calm ▪ *School personnel should not drive student to hospital*

INSTRUCTIONS for QUICK RELIEF INHALER USE: (HEALTH PROVIDER: PLEASE CHECK APPROPRIATE BOX(ES)
☐ Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently
☐ Student is to notify his/her designated school health officials after using inhaler.
☐ Student needs supervision or assistance to use his/her inhaler.
☐ Student has life threatening allergy, refer to anaphylaxis plan.

_____ _____ _____
HEALTH CARE PROVIDER SIGNATURE PLEASE PRINT PROVIDER'S NAME DATE

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 physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

_____ _____
PARENT SIGNATURE DATE

☐ 504 Plan or IEP

_____ _____
School Nurse Signature DATE

Copies of plan provided to: Teachers __ Phys Ed/Coach __ Principal___ Main Office __ Bus Driver __ Other _____

CDE Regional Nurse Specialists (http://www.cde.state.co.us/HealthAndWellness/SNH_Nursing-Asthma.htm) June 2011

OTHER MEDS

_____phone
_____fax

Pikes Peak Regional Policy on Student Medication

Within Policy Guidelines of Falcon School District 49

Parents are encouraged to administer medication to their children outside of school hours if at all possible. Only medications which are required to enable a student to stay in school may be given at school. If necessary, medications (prescription and over the counter) can be given at school under the following conditions:

1. All medications must be ordered by healthcare providers with prescriptive authority in CO (MD's, DO's, NP's, PA's).
2. All medication forms must be renewed **each school year.**
3. Written permission by parent and physician is required in all cases.
4. Medications must be in the original, properly labeled container. Medications sent in baggies or unlabeled containers will not be given.
5. All medications must be kept in the health room, except for students whose doctor requires them to carry medications on their person (for example, epipen, inhaler, etc).
6. Nurses, health assistants, and all medications kept in the health room are **not** available/accessible for before and after school activities. Please discuss your child's health concerns/medications with the activity coordinator.
7. See School Board Policy JLCD and JLCD – R for more information.

The information below must be completed and signed by the physician.

STUDENT NAME: _____ _____
First Name Last Name

DIAGNOSIS: _____ GRADE: _____ DOB: _____

MEDICATION: _____ DOSAGE: _____

TIME TO BE GIVEN: _____ ROUTE: _____

POSSIBLE SIDE EFFECTS:_____

Anticipated time frame: (Must be renewed each school year)
School Year: _____ OR Specific Time Frame: FROM: _____ TO: _____

If PRN (as needed), please note the minimum duration time between doses (for inhalers: minimum time frequency, frequency between sets of inhalation): _____

Is a second dose of epinephrine allowed if there is an allergic reaction? YES_____ NO_____

If medication is an inhaler or epinephrine, is the student given permission to carry on his/her person?
YES: _____ NO: _____ **Physician/NP/PA MUST SIGN BELOW**
Parent Signature:_____Date:_____ Student Signature:_____ Date:_____
School Nurse Signature:_____ Date:_____

Date: _____ **Printed Name Physician/NP/PA:** _____ **Physician/NP/PA Phone Number:** _____

Signature Physician/NA/PA: _____

Date: _____ School Nurse Signature: _____

I hereby give permission for my student to take the above prescription(s) at school as ordered by the physician. I understand that it is my responsibility to furnish this medication(s). I also understand that all medications must be transported to and from school by a parent/guardian or approved emergency contact person.

Date: _____ **Parent/Guardian Signature**: _____