

# Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

Student's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade: \_\_\_\_\_  
 School: \_\_\_\_\_ Teacher: \_\_\_\_\_  
 ALLERGY TO: \_\_\_\_\_  
 HISTORY: \_\_\_\_\_

Place child's photo here

Asthma:  YES (higher risk for severe reaction)  NO

## ◇ 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 2<sup>nd</sup> 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, 2<sup>nd</sup> 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: \_\_\_\_\_