BISD FOOD/INSECT & EMERGENCY HEALTH CARE PLAN and MEDICATION AUTHORIZATION

School Name _____**Date** _____**School Year** _____

Student Name	Date of Birth	Student #	Bus #
Grade:	Parent/Guardian Phone #s		
Parent/Guardian	Parent/Guardian Phone #s		
Emergency Contact	Contact Phone #s		

Place student's picture here

Extremely reactive to the following:

History of Asthma? ☐ **No** ☐ **Yes**

(*Asthma may indicate an increased risk of severe reaction*)

History of SEVERE Anaphylactic Reaction? ☐ **No** ☐ **Yes,**

If checked **YES**, give epinephrine immediately!
Give epinephrine if allergen was ***likely*** eaten, at onset of ***any*** symptoms or if allergen was **definitely** eaten even if **no** symptoms are noticed.

TREATMENT PLAN

FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:

LUNG: **Difficulty breathing or swallowing, wheezing, coughing**
HEART: **Dizzy, faint, confused, pale, blue, weak pulse**
THROAT: **Tight, hoarse, trouble breathing/swallowing, drooling**
MOUTH: **Significant swelling of tongue, lips**
SKIN: **Many hives over body, widespread redness over body**
GUT: **Nausea, repetitive vomiting, severe diarrhea, cramping**
Other: **Feeling something bad is about to happen, anxiety, confusion**

FOLLOW THIS PROTOCOL:

1. **INJECT EPINEPHRINE IMMEDIATELY!** (Note time)
2. **Call 911.** Request ambulance with epinephrine.
3. Don't hang up & don't leave student
4. Give additional medications as ordered
   - Antihistamine (if ordered below)
   - Inhaler (Albuterol) if student has asthma
5. Lay student flat and raise legs. If breathing is difficult or vomiting, sit up or lie on their side
6. Notify School Nurse and Parent/Guardian
7. Notify Prescribing Provider / PCP
8. Student must be transported to ER

☐ **MILD ALLERGY SYMPTOMS (IF DIAGNOSIS CONFIRMED ABOVE):**

MOUTH: **Itchy mouth, lips, tongue and/or throat**
SKIN: **Itchy mouth**
NOSE: **Itchy/runny nose**
GUT: **Mild nausea/discomfort**

1. **GIVE ANTIHISTAMINE** as directed
2. Monitor student; alert emergency contacts
3. Watch student closely for changes
4. **If symptoms worsen, GO TO EPINEPHRINE PROTOCOL (see above)**

➢ **THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL SYMPTOMS OF ANAPHYLAXIS CAN POTENTIALLY PROGRESS TO A LIFE THREATENING SITUATION!!**

MEDICATION ORDER

Epinephrine
Student's weight _____lbs.

☐ **Epinephrine (0.15mg)** inject intramuscularly
Epi Pen Auvi Q Adrenaclick

☐ **Epinephrine (0.3mg)** inject intramuscularly
Epi Pen Auvi Q Adrenaclick

A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.

Antihistamine
Do not depend on antihistamines (or inhalers).
When in doubt, give epinephrine and call 911.

☐ Benadryl/Diphenhydramine
Dose:
Route: PO
Frequency:

☐Other _____
Dose:
Route:

SIDE EFFECTS OF EPINEPHRINE MAY INCLUDE:
ANXIETY, TREMOR, PALPITATIONS, DIZZINESS, WEAKNESS, TINGLING, & PALENESS

NOTE: IF NURSE IS NOT AVAILABLE, THE ABOVE TREATMENT PLAN MAY BE PROVIDED BY TRAINED SCHOOL PERSONNEL FOR ANY ANAPHYLAXIS SYMPTOMS.

MUST BE COMPLETED BY HEALTHCARE PROVIDER, PARENT, AND SCHOOL NURSE

AUTHORIZATION

***Prescriber's Signature:** _____ **Date:** _____

Printed Name: _____ **Phone:** _____

I confirm student is capable to safely carry and properly administer above medication ☐ Yes ☐ No

Parent/Guardian Consent: I have received, reviewed and understand the above information. I approve of this Allergy Action Plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary. I assume full responsibility for providing the school with the prescribed medications. I give my permission for the school to share the above information with school staff that need to know about my child's condition.

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

I confirm my child is capable to safely carry and properly administer above medication ☐ Yes ☐ No

School Nurse:

I have reviewed this order and completed the allergy emergency care plan and shared with trained school personnel.

_____
Signature / Date

Medication Expires on:

_____