

# 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

## ◇ STEP 1: TREATMENT ◇

**Give epinephrine immediately if the allergen was definitely ingested, even if no symptoms**

**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/guardian 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 in \_\_\_\_\_ minutes, or if symptoms return, 2<sup>nd</sup> dose of epinephrine should be given, if available.

**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: \_\_\_\_\_

To be completed by healthcare provider

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**TRAINED/DELEGATED STAFF MEMBERS**

- |          |            |
|----------|------------|
| 1. _____ | Room _____ |
| 2. _____ | Room _____ |
| 3. _____ | Room _____ |

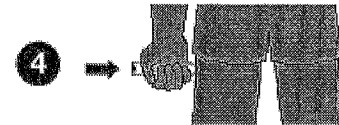
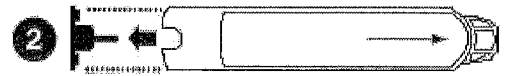
Self-carry contract on file.  Yes  No

Location of Medication: \_\_\_\_\_

EXPIRATION DATE OF EPINEPHRINE AUTO INJECTOR: \_\_\_\_\_

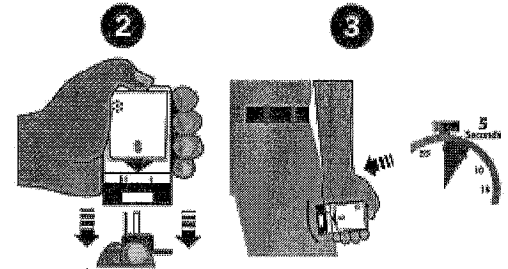
**EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS**

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



**AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS**

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



**ADRENALICK™/ADRENALICK™ GENERIC DIRECTIONS**

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



**NOTE:** Consider lying on the back with legs elevated. Alternative positioning may be needed for vomiting (side lying, head to side) or difficulty breathing (sitting)

Additional information: \_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_