

NM FOOD/INSECT & EMERGENCY ALLERGY ACTION PLAN and MEDICATION AUTHORIZATION

School District / School Name _____ Date _____

www.foodallergy.org

Student Name	Date of Birth	Student #
*Health Care Provider Name/Title	Provider's Office Phone / FAX #	
Parent/Guardian	Parent's Phone #s	
Emergency Contact	Contact Phone #s	



<p>Known Life-Threatening Allergies:</p> <p>Diagnosis of Mild Allergy? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Please list allergens:</p>	<p>History of Asthma? <input type="checkbox"/> No <input type="checkbox"/> Yes (Asthma may indicate an increased risk of severe reaction)</p> <hr/> <p>History of SEVERE Anaphylactic Reaction? <input type="checkbox"/> No <input type="checkbox"/> 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.</p>
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TREATMENT PLAN	<p>FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:</p> <p>LUNG: Difficulty breathing or swallowing, wheezing, coughing</p> <p>HEART: Dizzy, faint, confused, pale, blue, weak pulse</p> <p>THROAT: Tight, hoarse, trouble breathing/swallowing, drooling</p> <p>MOUTH: Significant swelling of tongue, lips</p> <p>SKIN: Many hives over body, widespread redness over body</p> <p>GUT: Nausea, repetitive vomiting, severe diarrhea, cramping</p> <p>Other: Feeling something bad is about to happen, anxiety, confusion</p>	<p>FOLLOW THIS PROTOCOL:</p> <ol style="list-style-type: none"> INJECT EPINEPHRINE IMMEDIATELY! (Note time) Call 911. Request ambulance with epinephrine. Don't hang up & don't leave student Give additional medications as ordered <ul style="list-style-type: none"> • Antihistamine (if ordered below) • Inhaler (Albuterol) if student has asthma Lay student flat and raise legs. If breathing is difficult or vomiting, sit up or lie on their side Notify School Nurse and Parent/Guardian Notify Prescribing Provider / PCP Student must be transported to ER
	<p><input type="checkbox"/> MILD ALLERGY SYMPTOMS (IF DIAGNOSIS CONFIRMED ABOVE):</p> <p>MOUTH: Itchy mouth, lips, tongue and/or throat</p> <p>SKIN: Itchy mouth</p> <p>NOSE: Itchy/runny nose</p> <p>GUT: Mild nausea/discomfort</p>	<ol style="list-style-type: none"> GIVE ANTIHISTAMINE as directed Monitor student; alert emergency contacts Watch student closely for changes 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	<p>Epinephrine</p> <p>Student's weight _____ lbs.</p>	<p><input type="checkbox"/> Epinephrine (0.15mg) inject intramuscularly Epi Pen Auvi Q Adrenaclick</p> <p><input type="checkbox"/> Epinephrine (0.3mg) inject intramuscularly Epi Pen Auvi Q Adrenaclick</p> <p>A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.</p>	
	<p>Antihistamine</p> <p>Do not depend on antihistamines (or inhalers). <i>When in doubt, give epinephrine and call 911.</i></p>	<p><input type="checkbox"/> Benadryl/Diphenhydramine</p> <p>Dose: _____ Route: PO Frequency: _____</p> <p><input type="checkbox"/> Other _____ Dose: _____ Route: _____</p>	<p>SIDE EFFECTS OF EPINEPHRINE MAY INCLUDE: ANXIETY, TREMOR, PALPITATIONS, DIZZINESS, WEAKNESS, TINGLING, & PALENESS</p>
	<p>NOTE: IF NURSE IS NOT AVAILABLE, THE ABOVE TREATMENT PLAN MAY BE PROVIDED BY TRAINED SCHOOL PERSONNEL FOR ANY ANAPHYLAXIS SYMPTOMS.</p>		

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

AUTHORIZATION	<p>*Prescriber's Signature: _____ Date: _____</p> <p>Printed Name: _____ Phone: _____</p> <p><i>I confirm student is capable to safely carry and properly administer above medication</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>School Nurse:</p> <p>I have reviewed this order and completed the allergy emergency care plan and shared with trained school personnel.</p>
	<p>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.</p>	<p>_____</p> <p style="text-align: center;">Signature / Date</p> <p>_____</p>
	<p>Parent/Guardian Signature: _____ Date: _____</p> <p><i>I confirm my child is capable to safely carry and properly administer above medication</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Medication Expires on:</p> <p>_____</p>
	<p style="text-align: center;">Goal: Patent Airway</p>	