NAUGATUCK PUBLIC SCHOOLS HEALTH SERVICES

SCHOOL_____ **PHONE/NUMBERS:**_____

Food/Insect Allergy Action Plan and Medication Authorization

Student's Name: _____**D.O.B.** _____**Grade:**_____

ALLERGY TO:_____ **Oral Allergy Syndrome: yes** ☐ **Allergen**_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

STEP 1: TREAT SYMPTOMS

Symptoms:		**Give Checked Medication**:** (**To be determined by physician authorizing treatment)	
• If a food allergen has been ingested**, but no symptoms**:		☐ Epinephrine	☐Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐Antihistamine
• Throat*	Tightening of throat, hoarseness, hacking cough**: immediately give**	☐ **Epinephrine 1st then:**	☐Antihistamine
• Lung*	Shortness of breath, repetitive coughing, wheezing: **immediately give**	☐ **Epinephrine 1st then**:	☐Antihistamine
• Heart*	Thready pulse, low blood pressure, fainting, pale, blueness**: immediately give**	☐ **Epinephrine 1st then:**	☐Antihistamine
• Other*		☐ Epinephrine	☐Antihistamine

• * ***If reaction is progressing OR if 2 or more of the above areas are affected, immediately give*: ☐ Epinephrine**

The severity of symptoms can quickly change. Potentially life-threatening. Asthma inhalers and/or antihistamines cannot be depended on to replace Epinephrine

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® 0.3mg EpiPen Jr® 0.15mg

Epinephrine order:_____
medication/dose/route

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

Benadryl order:(medication/dose/route)_____

☐ For OAS symptoms only:continue assessing for effectiveness and resolving symptoms. If resolved, may return to class(**for OAS only**) otherwise- send home to parent/guardian if symptoms persist.

**Treat for progressive signs and symptoms of anaphylaxis as noted above.

STEP 2: EMERGENCY CALLS -after Epipen administration ALWAYS:

1. Call 911. Send to _____(Hospital of choice) State that an allergic reaction has been treated and additional epinephrine may be needed, Notify MD, parent/guardian and Nursing Supervisor after student is stabilized
2. Emergency contact:_____ Phone Number(s)_____

NOTE: IF NURSE IS NOT AVAILABLE, THE EPINEPHRINE AUTO-INJECTOR MAY BE GIVEN BY DESIGNATED TRAINED SCHOOL PERSONNEL FOR ANY ANAPHYLAXIS SYMPTOMS AS INSTRUCTED ABOVE

AUTHORIZATION		**Prescriber's Signature:**	**Date:** **From** _____ **To**_____
		Prescriber's Authorization to Self-Administer: ☐ Yes ☐ No	**PRESCRIBER'S PRINTED NAME OR STAMP**
		Parent/Guardian: I hereby request that the above ordered medication be administered by school personnel and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. This protocol will be in effect until the end of the current or extended school year. This medication will be destroyed if not picked up within one week following termination of the order or the end of the school year, whichever comes first, unless the student will be attending an extended school year (ESY) program. A new protocol will be needed for the next school year. I have received, reviewed and understand the above information.	
		Parent/Guardian Signature:	**Date:**
		Parent/Guardian Authorization to Self-Administer: ☐ Yes ☐ No **School Nurse's Authorization for Self Administration** ☐Yes ☐ No School Nurse evaluated student and verifies student is competent to self carry(MS&HS) _____ RN	

Revised 1/17 ds