

# 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><b>Known Life-Threatening Allergies:</b></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 <i>(Asthma may indicate an increased risk of severe reaction)</i></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 <b>likely</b> eaten, at onset of <b>any</b> symptoms or if allergen was <b>definitely</b> eaten even if <b>no</b> symptoms are noticed.</p>
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<b>TREATMENT PLAN</b>	<p><b>FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:</b></p> <p><b>LUNG:</b> Difficulty breathing or swallowing, wheezing, coughing</p> <p><b>HEART:</b> Dizzy, faint, confused, pale, blue, weak pulse</p> <p><b>THROAT:</b> Tight, hoarse, trouble breathing/swallowing, drooling</p> <p><b>MOUTH:</b> Significant swelling of tongue, lips</p> <p><b>SKIN:</b> Many hives over body, widespread redness over body</p> <p><b>GUT:</b> Nausea, repetitive vomiting, severe diarrhea, cramping</p> <p><b>Other:</b> Feeling something bad is about to happen, anxiety, confusion</p>	<p><b><u>FOLLOW THIS PROTOCOL:</u></b></p> <ol style="list-style-type: none"> <li>1. <b>INJECT EPINEPHRINE IMMEDIATELY!</b> (Note time)</li> <li>2. <b>Call 911.</b> Request ambulance with epinephrine.</li> <li>3. Don't hang up &amp; don't leave student</li> <li>4. Give additional medications as ordered                         <ul style="list-style-type: none"> <li>• Antihistamine (if ordered below)</li> <li>• Inhaler (Albuterol) if student has asthma</li> </ul> </li> <li>5. Lay student flat and raise legs. If breathing is difficult or vomiting, sit up or lie on their side</li> <li>6. Notify School Nurse and Parent/Guardian</li> <li>7. Notify Prescribing Provider / PCP</li> <li>8. Student must be transported to ER</li> </ol>
	<p><input type="checkbox"/> <b>MILD ALLERGY SYMPTOMS (IF DIAGNOSIS CONFIRMED ABOVE):</b></p> <p><b>MOUTH:</b> Itchy mouth, lips, tongue and/or throat</p> <p><b>SKIN:</b> Itchy mouth</p> <p><b>NOSE:</b> Itchy/runny nose</p> <p><b>GUT:</b> Mild nausea/discomfort</p>	<ol style="list-style-type: none"> <li>1. <b>GIVE ANTIHISTAMINE</b> as directed</li> <li>2. Monitor student; alert emergency contacts</li> <li>3. Watch student closely for changes</li> <li>4. <b>If symptoms worsen, GO TO EPINEPHRINE PROTOCOL (see above)</b></li> </ol>

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

<b>MEDICATION ORDER</b>	<p><b>Epinephrine</b></p> <p>Student's weight _____ lbs.</p>	<p><input type="checkbox"/> <b>Epinephrine (0.15mg)</b> inject intramuscularly Epi Pen Auvi Q Adrenaclick</p> <p><input type="checkbox"/> <b>Epinephrine (0.3mg)</b> inject intramuscularly Epi Pen Auvi Q Adrenaclick</p> <p><b>A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.</b></p>	<p>SIDE EFFECTS OF EPINEPHRINE MAY INCLUDE: ANXIETY, TREMOR, PALPITATIONS, DIZZINESS, WEAKNESS, TINGLING, &amp; PALENESS</p>
	<p><b>Antihistamine</b></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><b>NOTE: IF NURSE IS NOT AVAILABLE, THE ABOVE TREATMENT PLAN MAY BE PROVIDED BY TRAINED SCHOOL PERSONNEL FOR ANY ANAPHYLAXIS SYMPTOMS.</b></p>			

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

<b>AUTHORIZATION</b>	<p><b>*Prescriber's Signature:</b> _____ <b>Date:</b> _____</p> <p><b>Printed Name:</b> _____ <b>Phone:</b> _____</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><b>School Nurse:</b></p> <p>I have reviewed this order and completed the allergy emergency care plan and shared with trained school personnel.</p>
	<p><b>Parent/Guardian Consent:</b> 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><b>Parent/Guardian Signature:</b> _____ <b>Date:</b> _____</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>_____</p> <p style="text-align: center;"><b>Signature / Date</b></p> <p>_____</p> <p><b>Medication Expires on:</b></p> <p>_____</p>
	<p><b>Goal: Patent Airway</b></p>	