

ALLERGY & ANAPHYLAXIS Individualized Healthcare Plan (IHP)/Emergency Action Plan (EAP)/Medication Authorization and Self-Administration Form In Accordance with UCA 26-41-104 Utah Department of Health/Utah State Board of Education		School Year:	
STUDENT INFORMATION		Student Number:	
Asthma: <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, high risk for severe reaction, please also complete Asthma Action Plan)			
Student:	DOB:	Grade:	School:
Parent:	Phone:	Email:	
Physician:	Phone:	Fax or email:	
School Nurse:	School Phone:	Fax or email:	
ALLERGEN(S):			
<input type="checkbox"/> If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms. <input type="checkbox"/> If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent. <input type="checkbox"/> Other:			
Yellow: Mild to Moderate Reaction		Action	
<i>MILD Symptoms</i> <ul style="list-style-type: none"> Itchy/runny nose Itchy mouth A few hives, mild itch Mild nausea/discomfort 		For MILD SYMPTOMS from A SINGLE SYSTEM area, follow the directions below: <ul style="list-style-type: none"> Antihistamines may be given, if ordered by a healthcare provider. Stay with the person; alert emergency contacts. Watch closely for changes. If symptoms worsen, give epinephrine. <p style="text-align: center;">For MORE THAN ONE symptom, GIVE EPINEPHRINE</p>	
Red: Severe Reaction		Action	
<i>SEVERE Symptoms</i> <ul style="list-style-type: none"> Short of breath, wheezing, repetitive cough Skin color is pale, blue, Faint, weak pulse, dizzy Tight, hoarse, trouble breathing or swallowing Significant swelling of the tongue and/or lips Many hives over body, widespread redness Repetitive vomiting, severe diarrhea Feeling something bad is about to happen, anxiety, confusion 		<ol style="list-style-type: none"> INJECT EPINEPHRINE IMMEDIATELY. Call 911. Tell them the child is having anaphylaxis and may need epinephrine when they arrive. Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side. Give second dose of epinephrine if symptoms get worse, continue, or do not get better in 5 minutes. Alert emergency contacts. Give other medication (only if prescribed). DO NOT use other medication in place of epinephrine. <ul style="list-style-type: none"> Antihistamine Inhaler (bronchodilator) if wheezing Transport them to emergency department even if symptoms resolve. Person should remain in ED for at least 4 hours because symptoms may return. 	
Additional Information: <input type="checkbox"/> Parent will provide all snacks <input type="checkbox"/> Teacher may provide snacks after reading labels carefully <input type="checkbox"/> May eat food processed on the same equipment as the allergen (tree nuts/peanuts)			
Additional Instruction:			
Medication Brand		Dose	Side Effects
Epinephrine:		<input type="checkbox"/> 0.15 mg IM <input type="checkbox"/> 0.3 mg IM	
Antihistamine:			

Allergy & Anaphylaxis Action Plan

Student Name:		DOB:	School Year:
PRESCRIBER TO COMPLETE			
<p>The above named student is under my care. The above reflects my plan of care for the above named student.</p> <p><input type="checkbox"/> It is medically appropriate for the student to self-carry Epinephrine Auto Injector (EAI) medication. The student should be in possession of EAI medication and supplies at all times.</p> <p><input type="checkbox"/> Student can self-carry and self-administer EAI if needed, when able and appropriate.</p> <p><input type="checkbox"/> Student can self-carry, but not self-administer EAI.</p> <p><input type="checkbox"/> It is not medically appropriate to carry and self-administer this EAI medication. Please have the appropriate/designated school personnel maintain this student's medication for use in an emergency.</p> <p><input type="checkbox"/> Additional Orders:</p>			
Prescriber Name:		Phone:	
Prescriber Signature:		Date:	
PARENT TO COMPLETE			
<p>Parental Responsibilities:</p> <ul style="list-style-type: none"> • The parent or guardian is to furnish the Epinephrine Auto Injector medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name. • The parent or guardian, or other designated adult will deliver to the school and replace the Epinephrine Auto Injector medication within two weeks if the Epinephrine Auto Injector single dose medication is given. • If a student has a change in their prescription, the parent or guardian is responsible for providing the newly prescribed information and dosing information as described above to the school. The parent or guardian will complete an updated Epinephrine Auto Injector Medication Authorization and Self-Administration Form (this form) before the designated staff can administer the updated Epinephrine Auto Injector medication prescription. 			
Parent/Guardian Authorization			
<p><input type="checkbox"/> I authorize my child to carry the prescribed medication described above. My student is responsible for, and capable of, possessing an epinephrine auto-injector per UCA 26-41-104. My child and I understand there are serious consequences for sharing any medication with others.</p> <p><input type="checkbox"/> I authorize my student to self-carry and self-administer EAI if needed, when able and appropriate.</p> <p><input type="checkbox"/> I authorize my student to self-carry, but not self-administer EAI.</p> <p><input type="checkbox"/> I do not authorize my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency.</p>			
Parent Signature:			Date:
<p><i>As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in this emergency action plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with allergy/anaphylaxis treatment, provided the personnel are following prescriber instruction as written in the emergency action plan above. Parent/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider and the school nurse if necessary for allergy management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.</i></p>			
Parent Name (print):		Signature:	Date:
Emergency Contact Name:		Relationship:	Phone:
SCHOOL NURSE (or principal designee if no school nurse)			
<input type="checkbox"/> Signed by prescriber and parent		<input type="checkbox"/> Medication is appropriately labeled	<input type="checkbox"/> Medication Log generated
EAI is kept: <input type="checkbox"/> Student Carries <input type="checkbox"/> Backpack <input type="checkbox"/> Classroom <input type="checkbox"/> Health Office <input type="checkbox"/> Front Office <input type="checkbox"/> Other (specify):			
Allergy & Anaphylaxis EAP distributed to 'need to know' staff: <input type="checkbox"/> Teacher(s) <input type="checkbox"/> PE teacher(s) <input type="checkbox"/> Transportation <input type="checkbox"/> Front Office/Admin <input type="checkbox"/> Other (specify):			
School Nurse Signature:			Date: