This protocol is in effect until the end of the current school year unless renewed and initialed by provider

School Emergency Allergy Plan: Food or Insect

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL **as stated** *in accordance with CT State Law and Regulations 10-212a*

Student Name ____DOB______________ History of Asthma ☐Yes ☐No

Home Phone__________________________ Work Phone_____________________ Cell_______________________

Health Care Provider Name(s)____ Phone________________________

Food or Insect Allergen(s)	History of Anaphylaxis	History of Oral Allergy Syndrome	Date of Allergy Testing
	☐Yes ☐No	☐Yes ☐No	
	☐Yes ☐No	☐Yes ☐No	
	☐Yes ☐No	☐Yes ☐No	

- **Notify provider if treatment received**
- **Administer bronchodilator after epi-pen if student has a history of asthma**
- **Call 911 for ED evaluation if Epi Pen administered** (Side Effects include tachycardia, tremors, nausea, dizziness, anxiety)

Potential Life-Threatening Allergen(s)

ANAPHYLAXIS MANAGEMENT

IF STUDENT INGESTS / IS STUNG OR IS THOUGHT TO HAVE BEEN EXPOSED TO THE FOLLOWING:

1. Observe student for symptoms of anaphylaxis*
2. ☐ Administer Epi Pen IM for ***any*** symptoms of anaphylaxis: ☐ 0.15Mg ☐ 0.3Mg
   - Prescriber authorization to self-administer ☐ Yes ☐ No
     - *Confirms student is capable to safely and properly administer medication*
3. ☐ Administer PO Benadryl (Diphenhydramine) ☐ 25mg 50mg (Side Effects include drowsiness, dizziness, dry mouth) ☐

☐Do not Administer Benadryl Other:____

ORAL ALLERGY SYNDROME (OAS) MANAGEMENT

IF STUDENT INGESTS OR IS THOUGHT TO HAVE BEEN EXPOSED TO THE FOLLOWING & SYMPTOMS ARE LIMITED TO THE LIPS, MOUTH, AND TONGUE:

1. ☐ Administer Benadryl (Diphenhydramine) ☐ 25mg ☐50mg ☐

☐ Do not Administer Benadryl Other:____

2. Observe student for progressing symptoms of anaphylaxis*
3. ☐ Administer Epi Pen IM for ***any additional*** symptoms of anaphylaxis: 0.15Mg 0.3Mg
   - Prescriber authorization to self-administer ☐ Yes ☐ No
     - *Confirms student is capable to safely and properly administer medication*

Known Oral Allergy Syndrome Allergen(s)

____
Date **Health Care Provider Signature**

Date Renewed/Initials_____________
Date Renewed/Initials_____________

____
Stamp or Printed Name

Parent/Guardian: I have reviewed and agree with the above medication administration protocol. I authorize communication between the prescribing health care provider and school nurse necessary for the safe implementation of this treatment protocol as long as it is in effect.

____
Date **Parent/Guardian Signature**

Parent/Guardian authorization to self-administer medication ☐ Yes ☐ No

____
Date **Parent/Guardian Signature**

***Symptoms of LIFE-THREATENING anaphylaxis:**

Usually occurs within minutes, but may occur up to 2 hours after exposure

- Facial, lips, tongue swelling
- Chest tightness, wheezing, cough, shortness of breath
- Dizziness, fainting, "feeling of impending doom"
- Itchy skin, hives
- Difficulty swallowing, tightness in throat
- Abd cramping, nausea, vomiting