

ALLERGY TREATMENT PROTOCOL

Name of child: _____ Grade: _____ Date of birth: _____

Condition for which drug(s) are being administered during school hours: _____

PRESCRIBER'S ORDER: IF CHILD IS EXPOSED TO, INGESTS, OR IS STUNG, FOLLOW THE SELECTED TREATMENT PLANS (A or B).

PLAN A:

MD's
Initials

Immediately administer epinephrine (adrenaline) by intramuscular injection, **without waiting** to see whether or not signs of allergic reaction occur. Call 911 for transport to the emergency room.
Administer an antihistamine by mouth.

Epipen Jr. 0.15 mg intramuscularly

Epipen 0.3 mg intramuscularly

AND OTC medication:

Diphenhydramine elixir 12.5 mg/ml (Benadryl):

Administer by mouth

Mark dosage: 12.5 mg

25 mg

50 mg

No antihistamine

OR

PLAN B:**

MD's
Initials

Administer an antihistamine by mouth, observe the patient for signs of symptoms of allergy* for one hour. **If signs or symptoms of allergy* occur, administer epinephrine by injection and call 911** for transport to the emergency room.

Diphenhydramine elixir 12.5 mg/ml (Benadryl):

Administer by mouth

Mark dosage: 12.5 mg

25 mg

50 mg

***If signs or symptoms of allergy occur administer epinephrine**

Epipen Jr. 0.15 mg intramuscularly

Epipen 0.3 mg intramuscularly

***SIGNS AND SYMPTOMS OF AN ALLERGIC REACTION INCLUDE:**

MOUTH

itching and swelling of lips, tongue

THROAT

itching of throat, sense of tightness in the throat, hoarseness, difficulty swallowing

SKIN

hives, itchy, rash, swelling of face or extremities

GUT

nausea, abdominal cramps, vomiting, diarrhea

LUNG

shortness of breath, repetitive coughing, wheezing, chest tightness

CARDIOVASCULAR

dizziness, faintness, loss of consciousness

Medication to be administered from _____ to _____.

Time of Administration: **See treatment plan above: CIRCLE PLAN A or B.**

Relevant side effects to be observed, if any: Epipen=jitters & tachycardia; Benadryl=sedation. If there are side effects, plan for management: Call physician if symptoms do not resolve spontaneously.

****ON FIELD TRIPS OR IN THE ABSENCE OF A NURSE: DO NOT HESITATE TO GIVE MEDICATION OR CALL 911.**

Physician's Signature: _____ Date: _____

Physician's Name (printed): _____ Telephone # _____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION BY SCHOOL PERSONNEL:

To School Personnel:

I hereby request that the above medication, ordered by the MD, DDS, OD, APRN or PAC for my child be administered by school personnel. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 45 school day supply of said medication. I understand that this medication will be destroyed if it is not picked up by the last day of school.

Signature: _____ Relationship to student: _____ Date: _____

Name: _____ Telephone: (H) _____ (W) _____