



Great Falls Public Schools – Allergy/Anaphylaxis Emergency Care Plan

Student Name:	ID:	School:	Grade:	Teacher:
DOB:	Plan Year:	School Nurse:	Phone#:	
Does the student have any of the following plan(s)? 504 Y/N IEP Y/N		Does the student ride the school bus? Y/N		
Parent/Guardian:		Phone #:		
Emergency Contact:		Phone #:		
Primary Provider:		Specialist:		
Drug Allergies:		Daily Medications:		

Known Allergen(s):

Does this student also have asthma? Y / N (If yes, higher risk for severe reaction)	☐ Child has an extreme SEVERE allergy to: _____ Should be given epinephrine at the first sign of any symptoms even if mild
Does this student need to eat at a nut free table? Y / N NA	Diet Order Form on file? Y/N

For ANY of the following SEVERE symptoms do not hesitate to use an Epi pen...

OR for a COMBINATION of symptoms from 2 or more body systems

ANAPHYLAXIS RECOGNITION: ASSESS AND ACT QUICKLY				
 LUNG Short of breath, wheeze, repetitive cough, chest tightness, blue skin and/or lip color	 HEART Pale, blue, faint, weak pulse, dizzy, or confused	 THROAT Tightness, hoarse, trouble breathing or swallowing	 MOUTH Swelling of tongue, lips or back of throat	MILD SYMPTOMS NOSE Itchy or runny nose, sneezing MOUTH Itchy mouth SKIN A few hives, mild itch GUT Mild nausea or discomfort
 SKIN Widespread redness or hives, or eye swelling	 GUT Repetitive vomiting, severe diarrhea, or abdominal cramps	 OTHER Feeling of doom, confusion or loss of consciousness		
Do not depend on antihistamines or inhalers to treat severe reactions. Use Epinephrine				

FOR TREATMENT OF ANAPHYLAXIS

1. Administer Epi Pen. (**Do not delay administration of epinephrine for any signs of anaphylaxis**)
2. Call 911.
3. Consider additional medications if ordered and available (☐ Antihistamine ☐ Inhaler)
4. Lay the student flat with legs elevated. If difficulty breathing or vomiting, turn on side
5. Notify Parents and School Nurse
6. If symptoms do not improve, or symptoms return, administer a second dose of epinephrine if it has been 5 minutes or more since the first dose.
7. Refer student to ER for further evaluation and monitoring, even if symptoms have resolved.

FOR MILD REACTION (localized reaction in one body system)

1. Give antihistamine if ordered.
2. Notify parents and School Nurse
3. Monitor student closely for changes. **If symptoms worsen, give epinephrine**

MEDICATION/DOSES	
Epinephrine Auto-Injector:	
☐ Jr (0.15mg IM)	☐ Adult (0.3mg IM)
Antihistamine: _____	
Antihistamine Dose: _____	
Other (e.g. inhaler-bronchodilator): _____	
Location of medications: _____	

PERMISSION FOR STUDENT TO SELF ADMINISTER

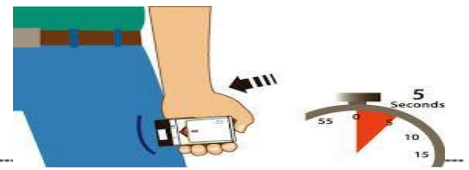
Healthcare provider confirms that student has been instructed in proper use of the medication(s) listed above and is able to self-administer without school personnel supervision. (If marked parent needs to sign authorization on page 2)

- ☐ Both the provider and the guardian feel that the child may carry and self-administer their Epinephrine
- ☐ School nurse agrees with student self-administering the Epinephrine

Physician:	Date:	Building Administrator:	Date:
Parent/guardian:	Date:	School Nurse:	Date:

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



HOW TO USE ADRENALICK/GENERIC EPINEPHRINE (IMPAX)

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

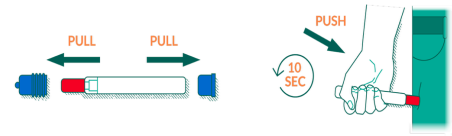
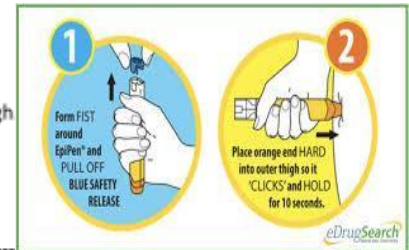


Figure A
STEP 1. Prepare epinephrine injection, USP auto-injector for injection

Figure B
STEP 2. Administer epinephrine injection, USP auto-injector

HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.



HOW TO USE NEFFY® (EPINEPHRINE NASAL SPRAY)

1. Remove neffy from packaging. Pull open the packaging to remove the neffy nasal spray device.
2. Hold device as shown. Hold the device with your thumb on the bottom of the plunger and a finger on either side of the nozzle. Do not pull or push on the plunger. Do not test or prime (pre-spray). Each device has only 1 spray.
3. Insert the nozzle into a nostril until your fingers touch your nose. Keep the nozzle straight into the nose pointed toward your forehead. Do not point (angle) the nozzle to the nasal septum (wall between your 2 nostrils) or outer wall of the nose.
4. Press plunger up firmly until it snaps up and sprays liquid into the nostril. Do not sniff during or after the dose is given. If any liquid drips out of the nose, you may need to give a second dose of neffy after checking for symptoms. Call 911 immediately after first use.
5. If symptoms don't improve or worsen within 5 minutes of initial dose, administer a second dose into the same nostril with a new neffy device.



For Students who carry and/or self-administer medications:

Authorization by parent/guardian: See generally Mont. Code Ann 20-5-420.

As the parent/guardian of the student named in this plan, I confirm this student has been instructed by his/her health care provider on the proper use of this/these medication(s). He/she demonstrated to me he/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self-medicate as listed above, if needed. If he/she has used epinephrine during school hours, he/she understands the need to alert the school nurse or other adult at the school who will provide follow-up care, including making a 9-1-1 emergency call.

- I acknowledge the school district or nonpublic school and its employees and agents are not liable as a result of any injury arising from the self-administration of medication by the student, and I indemnify and hold them harmless for such injury, unless the claim is based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.
- I agree to work with the school in establishing a plan for use and storage of backup medication. This will include a predetermined location to keep backup medication to which the student has access in the event of an asthma, severe allergy, or anaphylaxis emergency. I have provided the following backup medication: _____
- I understand in the event the medication dosage is altered, a new "self-administration form" must be completed, or the health care provider may rewrite the order on his/her prescription pad and I, the parent/caretaker relative/guardian, will sign the new form and assure the new order is attached.
- I understand it is my responsibility to pick up any unused medication at the end of the school year, and any medication not picked up will be disposed of.
- I authorize the school administration to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian signature: _____ Date: _____



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This form is adapted from Food Allergy Research & Education's Food Allergy & Anaphylaxis Emergency Care Plan (2025) www.foodallergy.org.
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Plan Documented: _____ EP _____ PS _____ Bus