Cedar Hill ISD Health Services

Allergy and Anaphylaxis Treatment Plan

Student's Name: _____**D.O.B:**_____ **Campus:** _____ **Grade:** _____

ALLERGY TO: ☐ Foods ☐ Latex ☐ Insect Bites ☐ Other: List allergens_____

Expected Type of Reaction: _____Asthmatic ☐ Yes ☐ No *Higher risk for severe reaction

STEP 1: TREATMENT

***Note: If a food allergen has been ingested, but No symptoms are present - observe student and contact parent**

Mild Symptoms Only
Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort

→

Give Antihistamine if available
Stay with child, alert nurse and parent/guardian
If Symptoms Progress go to Step 2 and Inject Emergency Medicine (EpiPen)

STEP 2: TREATMENT

Any Severe Symptoms After Suspected Ingestion:
Lung: Short of breath, wheezing, repetitive cough
Heart: Pale, blue, faint, weak pulse, dizzy, confused
Throat: Tightness, hoarseness, trouble swallowing, itching
Mouth: Tingling, swelling of lips and/or tongue
Skin: Hives, itchy rash all over, facial swelling
Gut: Vomiting, diarrhea, cramping, pain
Other: Anxiety, feeling of dread

→

Inject Epinephrine (EpiPen) Immediately
1.Place student in a supine or seated position
2. Administer Emergency medication
3. Call 911
4. Give additional medication such as Inhaler if student is asthmatic - if so indicated by physicians orders
5. If no improvement or symptoms worsens and EMS has not arrived , may need to give second dose
6. Contact Parent/Guardian immediately

***The severity of symptoms can quickly change. Symptoms can progress to life-threatening quickly. Do not hesitate to call 9-1-1. ***

Epinephrine: _____

Route and dose to administer

☐ Give second epinephrine dose after_____minutes if no improvement and EMS has not arrived.

Antihistamine: _____
Medication / Dose / Route

Other Medication to administer (ex. Inhaler) _____

Physician_____/_____/_____/_____
Print **Signature** **Date** **Telephone Number**

STEP 3: EMERGENCY CALLS

1. **Call 911. State that a child has had a possible allergic reaction and that epinephrine has been given. State how much, how long ago and the condition of the child.**
2. **Try to contact parent/guardian; if they cannot be reached, do not delay student from being taken to the nearest medical facility.**

I authorize administration of epinephrine to my child as prescribed by his/her physician in the event of an anaphylactic event. I understand that the school administration will designate trained staff to perform this procedure in accordance with the physician's orders as given above. If the medication is administered while at school, I will provide the school with replacement medication the next school day. I give my consent for the release of all medical records pertaining to my child's severe allergy reactions/anaphylaxis and permission for appropriate school staff to contact the physician or health care provider for additional information if needed. I also release the school/district from liability in the event adverse reactions result from giving this medication.

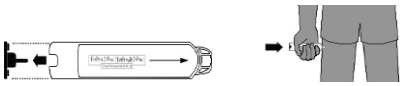
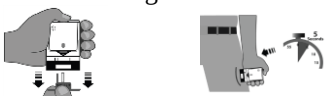
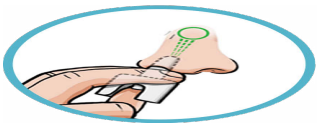
Parent/Guardian:
_____/_____/_____/_____
Print **Signature** **Date** **Telephone Number**

Allergy Action Plan – *page 2*

EMERGENCY CONTACTS

	Name	Relationship	Number(s)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

DIRECTIONS:

EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS	AUVI-QTM (EPINEPHRINE INJECTION, USP) DIRECTIONS	neffy®/epinephrine spray DIRECTIONS
1. Remove the EpiPen Auto-Injector from the plastic carrying case. 2. Pull off the blue safety release cap. 3. Swing and firmly push orange tip against mid-outer thigh. 4. Hold for approximately 10 seconds. 5. Remove and massage the area for 10 seconds. 	1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions. 2. Pull off red safety guard. 3. Place black end against mid-outer thigh. 4. Press firmly and hold for 5 seconds. 5. Remove from thigh. 	1. Remove Neffy from Packaging 2. Hold the device with your thumb on the bottom of the plunger. 3. Insert the nozzle into a nostril until your fingers touch your nose 4. Press plunger up firmly until it snaps up and sprays liquid into the nostril. 

Trained Staff:

1. _____ **Room #** _____ **Ext.** _____
2. _____ **Room #** _____ **Ext.** _____
3. _____ **Room #** _____ **Ext.** _____
4. _____ **Room #** _____ **Ext.** _____

SELF-ADMINISTRATION OF PRESCRIPTION ANAPHYLAXIS MEDICINE

(To be completed by the Authorizing Physician)

☐ It is my professional opinion that _____ (student's name) ***should*** be allowed to carry and self-administer _____ while on school property or at school-related events. I have instructed the student in the proper way to self-administer the anaphylaxis medicine. The student is knowledgeable about the medicine and how to administer it.

☐ It is my professional opinion that _____ (student's name) ***should <u>NOT</u>*** be allowed to carry and self-administer any of his/her anaphylaxis medicine while on school property or at school related events.

_____ /_____/_____
Physician (Print Name) **Signature** **Date**

(To be completed by Parent/ Legal Guardian)

<u>APPLICABLE ONLY IF THE CRITERIA HAS BEEN/ ARE BEING MET TO SELF-ADMINISTER PRESCRIPTION ANAPHYLAXIS MEDICINE</u>

I give permission for my student to self-administer the prescribed medication listed above, in accordance with the physician's order, while on school property or at a school-related event or activity. Self-administration must be done in compliance with the prescription and state law.

_____ /_____/_____
Parent/Guardian (print) **Signature** **Date**