Place Child's Picture Here

Management of Severe Allergic Reactions & Anaphylaxis

HEALTH LINK LLC

Student's Name: _____ **Date of Birth:** _____
Teacher's Name: _____ **Room #:** _____
ALLERGY TO: _____

_____

Asthmatic? (Y/N) _____ (Yes=Higher Risk for Severe Reaction)

STEP 1: TREATMENT

Symptoms	**Give This Medication**	
	Epinephrine	Antihistamine
If a food allergen is ingested or suspected bee sting, but *no symptoms*		
Mouth: itching, tingling, or swelling of lips, tongue mouth		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat *: Tightening of throat, hoarseness, hacking cough		
Lung*: Shortness of breath, repetitive coughing, wheezing		
Heart*: Weak or thread pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progression (several of the above areas affected):		

*Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE
Epinephrine: inject intramuscularly:

EpiPen® or generic _____ Epipen JR® or generic _____ Auvi-Q _____

Antihistamine: give _____

Other: give _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

Call 911 (or Rescue Squad). State that an allergic reaction has been treated and additional epinephrine made be needed.

_____ **Doctor's Name**
_____ **Doctor's Phone Number**

_____ **Parent's Name**
_____ **Parent's Phone Number**

_____ **Emergency Contact 1 Name/Relationship**
_____ **Emergency Contact 1 Phone Number**

EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

_____ **Parent Guardian's Signature/Date**
_____ **Doctor's Signature/Date**

Place Child's Picture Here

HEALTH LINK LLC

Prevention Plan

Student's Name: _____ Date of Birth: _____

Teacher's Name: _____ Room #: _____

ALLERGY TO: _____

_____

Asthmatic? Y/N) _____ (Yes=Higher Risk for Severe Reaction)

School will:

- ☐ A Certified Medication Technician on site with on-call Delegating RN
- ☐ Have staff trained in CPR & First Aid
- ☐ Have staff trained in Allergy & Anaphylaxis
  → administering EpiPen® including demonstration & practice
- ☐ Emergency List distributed to:_____
- ☐ Have staff trained on individual emergency plans
- ☐ School staff will make every reasonable effort to prevent the student's exposure to known allergens
- ☐ Other_____

Parents will:

- ☐ Provide pertinent health information to the school
- ☐ Provide Physician Authorization Forms and Action Plans
  → for student medication and specific actions plans for emergency care
- ☐ Current, non-expired medications
- ☐ Provide safe snack option to school/classroom
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

Student will:

- ☐ Make every effort to avoid contact with allergen
- ☐ Alert nearest adult if suspect exposure to allergen
- ☐ Other

Notes:

Asthma Medication Administration Authorization Form ASTHMA ACTION PLAN for

_____/_____/_____to_____/_____/_____(not to exceed 12 months) Name:_____DOB:_____PEAK FLOW PERSONAL BEST: _____

ASTHMA SEVERITY: ☐ **Exercise-induced** ☐ **Intermittent** ☐ **Mild Persistent** ☐ **Moderate Persistent** ☐ **Severe Persistent** **List Triggers:**

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE : Long Term Control Medication — use daily at home unless otherwise indicated

☐ Breathing is good
☐ No cough or wheeze
☐ Can work, exercise, play
☐ Other: _____
☐ Peak flow greater than_____(80% personal best)

Medication	Dose	Route	Frequency

☐ **Prior to exercise/sports/ physical education**

(Rescue Medication)			

If using more than twice per week for exercise, notify the health care provider and parent/guardian.

YELLOW ZONE: Quick Relief Medications — to be added to Green zone medications for symptoms

☐ Cough or cold symptoms
☐ Wheezing
☐ Tight chest or shortness of breath
☐ Cough at night
☐ Other: _____

☐ Peak flow between_____and _____
(50%-79% personal best)

Medication	Dose	Route	Frequency

If symptoms do not improve in_____minutes, notify the health care provider and parent/guardian.
If using more than twice per week, notify the health care provider and parent/guardian.

RED ZONE: Emergency Medications— Take these medications and call 911

☐ Medication is not helping within 15-20 mins
☐ Breathing is hard and fast
☐ Nasal flaring or skin retracts between ribs
☐ Lips or fingernails blue
☐ Trouble walking or talking
☐ Other:_____
☐ Peak flow less than_____(50% personal best)

Medication	Dose	Route	Frequency

Contact the parent/guardian after calling 911.

Health Care Provider and Parent Authorization with Review by RN

I authorize the school/camp staff to administer the above medications as indicated. Student may self-carry medications (School-age students only) ☐ **Yes** ☐ **No**

Prescriber signature & date: _____

Parent/Guardian signature & date: _____

By signing below, I certify that the student is authorized to self-carry/self-administer medication at school/camp and authorize the student to self-carry/self-administer the medications indicated during school or camp.

Prescriber signature & date: _____

Parent/Guardian signature: _____

Reviewed by DN/RN Health Supervisor

Name: _____

Signature/date: _____

_____

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