NM FOOD/INSECT & EMERGENCY ALLERGY ACTION PLAN and MEDICATION AUTHORIZATION

School District / School Name _____ **Date** _____ **School Year** _____

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Student Name	Date of Birth	Student #	**Epinephrine injector is stored in:** ☐ With Student ☐ Classroom ☐ Health Office ☐ _____
*Health Care Provider Name/Title	Provider's Office Phone / FAX #		
Parent/Guardian	Parent's Phone #s		
Emergency Contact	Contact Phone #s		
Student's weight: _____ **lbs.**	**Asthma:** ☐ YES (higher risk for a severe reaction) ☐ No		

Allergy to:

Give epinephrine immediately:

[ ] for ANY symptoms if allergen was likely eaten.

[ ] If allergen was definitely eaten, even if no symptoms are noticed.

TREATMENT PLAN

FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:

LUNG: Short of breath, wheezing, repetitive cough

HEART: Dizzy, faint, confused, pale, blue, weak pulse

THROAT: Tight, hoarse, trouble breathing/swallowing, drooling

MOUTH: Swelling of tongue, lips

SKIN: Many hives over body, widespread redness over body

GUT: Nausea, repetitive vomiting, severe diarrhea, cramping

Other: Feeling something bad is about to happen, anxiety, Confusion

OR A combination of mild symptoms from different body areas

FOLLOW THIS PROTOCOL:

1. **INJECT EPINEPHRINE IMMEDIATELY!** (Note time)
2. **Call 911.** Request ambulance with epinephrine. Don't hang up & don't leave student
   - Give additional medications as ordered [Antihistamine (if ordered below)] [Inhaler (Albuterol) if student has asthma]
   - Lay student flat and raise legs. If breathing is difficult or vomiting, sit up or lie on their side
   - Notify School Nurse and Parent/Guardian
   - Notify Prescribing Provider / PCP
   - When indicated, assist student to rise slowly
   - Student must be transported to ER

MILD ALLERGY SYMPTOMS:

MOUTH: Itchy mouth, lips, tongue and/or throat

SKIN: A few hives, itchy skin

NOSE: Itchy/runny nose, sneezing

GUT: Mild nausea/discomfort

1. GIVE ANTIHISTAMINE (as ordered below)
2. Stay with student; alert school nurse & parent/guardian
3. Watch student closely for changes
   - If symptoms worsen, **GIVE EPINEPHRINE**
   - For mild symptoms from more than one body area - **GIVE EPINEPRHINE** (see above).

➢ **THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL SYMPTOMS OF ANAPHYLAXIS CAN POTENTIALLY PROGRESS TO A LIFE THREATENING SITUATION!!**

MEDICATION ORDER

Epinephrine	☐ **Epinephrine (0.15mg)** inject intramuscularly Epi Pen Auvi Q Adrenaclick	☐ **Epinephrine (0.3mg)** inject intramuscularly Epi Pen Auvi Q Adrenaclick	
	A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.		
Antihistamine Do not depend on antihistamines or inhalers. ***When in doubt, give epinephrine and call 911.***	☐ Benadryl/Diphenhydramine Dose: _____mg. Route: PO	☐ Other _____ Dose: _____mg Route:	Note: If School Nurse is not available, the above treatment plan may be provided by trained school personnel for any anaphylaxis symptoms.

MUST BE COMPLETED BY PARENT AND AUTHORIZED HEALTH CARE PROVIDER

AUTHORIZATION

***Prescriber's Signature:** _____ **Date:** _____

Printed Name: _____ **Phone:** _____

Student is able to carry and self-administer his/her medication at school ☐ Yes ☐ No

Parent/Guardian Consent: I have received, reviewed and understand the above information. I approve of this Allergy Action Plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary. I assume full responsibility for providing the school with the prescribed medications. I give my permission for the school to share the above information with school staff that need to know about my child's condition.

Parent/Guardian Signature: _____ **Date:** _____

I confirm my child is capable to carry and administer above medication ☐ Yes ☐ No

School Nurse:

I have reviewed this order and completed the Allergy Emergency Care Plan and have trained school personnel.

_____

Signature / Date

Medication Expires on:

_____