SUMNER COUNTY SCHOOLS
ALLERGY/ANAPHYLAXIS EMERGENCY ACTION PLAN & MEDICATION ORDER

Student: _____ DOB: _____

School: _____ Grade/Teacher (homeroom): _____

History of Asthma (circle) YES or NO ***if yes, the student is at higher risk for severe reaction**

Extremely reactive to the following allergens: _____
THEREFORE:

- ☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.
- ☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if NO symptoms are apparent.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

IS THIS STUDENT COMPETENT TO CARRY & SELF-ADMINISTER EMERGENCY MEDICATION (circle) YES or NO

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG Shortness of breath, wheezing, repetitive cough

HEART Pale or bluish skin, faintness, weak pulse, dizziness

THROAT Tight or hoarse throat, trouble breathing or swallowing

MOUTH Significant swelling of the tongue or lips

SKIN Many hives over body, widespread redness

GUT Repetitive vomiting, severe diarrhea

OTHER Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve.

MILD SYMPTOMS

NOSE Itchy or runny nose, sneezing

MOUTH Itchy mouth

SKIN A few hives, mild itch

GUT Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.01 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

9/2018

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PARENT/GUARDIAN AKNOWLEDGMENTS & AUTHORIZATIONS:

- I want this plan implemented for my child.
- I authorize the school nurse, or nurse program representative, to contact and receive additional information from the prescribing physician, regarding the student's health plan, as needed. I understand this information will only be shared with staff on a "need to know" basis.
- If, for any reason, emergency medication is not available EMS (911) should be called immediately.
- **If my student self-administers his/her epinephrine** I understand it is the responsibility of the parent/guardian to provide backup epinephrine, in the event the student loses or forgets their medication.
- **If my child self-administers his/her epinephrine** I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of epinephrine.
- I**f my child self-administers his/her epinephrine** I understand it is my responsibility to review the following with my child:
  - Epinephrine must be with them at all times and never left unattended;
  - Ensure they know when (signs & symptoms) & how to use prescribed epinephrine;
  - He/she understands they must notify an adult in charge **immediately**, if epinephrine is used;
  - He/she will only use medication as prescribed and will never share with other students.

Parent/Guardian Signature: _____ Date: _____

Emergency Phone:

☐ **Check here if information was requested from the parent with no response, and this IHP was developed by the school nurse without parent input.**

School Nurse Name:	**Signature:**	**Date:**

PHYSICIAN/HEALTHCARE PROVIDER SIGNATURE:

Print:	**Signature:**	**Date:**

LOCATION OF BACKUP MEDICATION (if none, indicate reason): _____

If epinephrine given provide EMS with time and injector, if requested