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CONFIDENTIAL
Allergy/Anaphylaxis Action Plan
Medication Orders 2018-19

JEFFCO PUBLIC SCHOOLS
Building Bright Futures

Student:	DOB:	School/Grade:	Student ID:	Place child's Photo here
Parent/Guardian: 1. 2.	Cell: 1. 2.	Home: 1. 2.	Work/Alternate #: 1. 2.	
Physician:	Office:	Fax:	Hospital Preference:	

****Check Infinite Campus for current phone numbers & emergency contacts****

To Be Completed by Health Care Provider

ALLERGY TO: _____

HISTORY: _____

ASTHMA: ☐ **YES (Higher risk for severe reaction)** ☐ **NO**

♦ STEP 1: TREATMENT ♦

SEVERE SYMPTOMS: **Any of the following:**
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Significant swelling of the tongue and/or lips
SKIN: Many hives over body, widespread redness
GUT: Repetitive vomiting, severe diarrhea
OTHER: Feeling like something bad is going to happen, confusion

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1. **INJECT EPINEPHRINE IMMEDIATELY**
2. **Call 911** and activate emergency response team
3. Call Parent/Guardian and school nurse
4. Monitor student: Keep them lying down
5. Administer Inhaler (quick relief) if ordered
6. Be prepared to administer 2nd dose if needed

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

NOSE: Itchy, runny nose, sneezing
SKIN: A few hives, mild itch
GUT: Mild nausea/discomfort

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1. Alert parent/guardian and school nurse
2. Antihistamines may be given if ordered by a healthcare provider.
3. Continue to observe student
4. If symptoms progress **USE EPINEPHRINE**
5. Follow directions in above box

DOSAGE:

EPINEPHRINE: inject intramuscularly using auto injector (check one) ☒ **0.3mg** or ☐ **0.15mg**

☐ If symptoms do not improve in _____ minutes or more, or if symptoms return, give 2nd dose of epinephrine if available

☐ **Antihistamine:** (brand and dose) Benadryl(or generic)-check dose ☐12.5mg(1tsp) ☐25mg(2tsp) ☐37.5mg(3tsp) ☐50mg(4tsp)

Asthma Rescue inhaler: (brand and dose)_____

Student has been instructed and is capable of carrying and self-administering own medication. ☐ Yes ☐ No

Provider (print name):_____ Phone:_____

Provider's Signature: _____ Date:_____

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

♦ STEP 2: EMERGENCY CALLS ♦

1. **If epinephrine given, call 911.** State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. **Even if parent/guardian cannot be reached; do not hesitate to administer emergency medications.**

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child, and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature:_____ Date:_____

School Nurse:_____Elsie Osborne, RN_____ Date:_____9/2018_____