

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

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

School: _____ Teacher: _____

ALLERGY TO: _____

HISTORY: _____

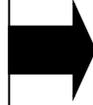


Asthma: YES (higher risk for severe reaction) NO

◇ STEP 1: TREATMENT ◇

SEVERE SYMPTOMS: Any of the following:

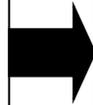
- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy,
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Significant swelling of the tongue and/or lips
- SKIN: Many hives over body, widespread redness
- GUT: Repetitive vomiting, severe diarrhea
-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



1. **INJECT EPINEPHRINE IMMEDIATELY**
 2. Call 911 and activate school 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 of epinephrine if needed
- *Antihistamine & quick relief inhalers are not to be depended upon to treat a severe food related reaction . **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

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



1. Alert parent 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): 0.3 mg 0.15 mg

If symptoms do not improve _____ minutes or more, or symptoms return, 2nd dose of epinephrine should be given

Antihistamine: (brand and dose) _____

Asthma Rescue Inhaler: (brand and dose) _____

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

Provider (print) _____ Phone Number: _____

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. Parent: _____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
 - a. _____ 1) _____ 2) _____
 - b. _____ 1) _____ 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: _____ Date: _____

To be completed by healthcare provider