ALLERGY & ANAPHYLAXIS ACTION PLAN

School Health Plan (SHP)
Emergency Action Plan (EAP)
Medication Authorization and Self-Administration Form
In Accordance with UCA 26-41-104
Utah Department of Health/Utah State Board of Education

PHOTO

CACHE COUNTY SCHOOL DISTRICT
Nursing & Health Services
Phone: 435-752-3925
Fax: 435-792-7796

RN Approval

Asthma: ☐ No ☐ Yes (If yes, high risk for severe reaction, please also complete Asthma Action Plan)

STUDENT INFORMATION

Student:	DOB:	School:	Grade:	Year:
Parent:	Phone:	Email:		
Physician:	Phone:	Email:		
School Nurse:	Phone:	Email:		

ALLERGEN(S)

Allergy to:

☐ 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.

☐ N/A – Follow in accordance with the yellow and red sections below.

YELLOW: Mild to Moderate Reaction	ACTION
MILD SYMPTOMS • Itchy/runny nose • Itchy mouth • A few hives, mild itching • Mild nausea/discomfort	For **MILD SYMPTOMS** from **A SINGLE SYSTEM** area, follow the directions below: • **Antihistamine** may be given, if ordered by a healthcare provider. • **Stay with the person**; **alert emergency contacts.** • Watch closely for changes. If symptoms worsen, give epinephrine. **FOR MORE THAN ONE SYMPTOM, GIVE EPINEPHRINE!**
RED: SEVERE REACTION	**ACTION**
SEVERE SYMPTOMS •Short of breath, wheezing, repetitive coughing •Skin color is pale, blue •Faint, dizzy, weak pulse •Tight, hoarse, trouble breathing or swallowing •Significant swelling of the tongue and or lips •Many hives over body, widespread redness •Repetitive vomiting, severe diarrhea •Feeling something bad is about to happen, anxiety, confusion	1. **INJECT EPINEPHRINE IMMEDIATELY!** 2. Call 911 (EMS). Tell them the child is having anaphylaxis and may need Epinephrine when they arrive. 3. 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. 4. Give second dose of epinephrine if symptoms get worse, continue, or do not get better in 5 minutes. 5. Alert emergency contacts. 6. Give other medication (ONLY IF PRESCRIBED). **DO NOT** use other medication in place of Epinephrine. • Antihistamine • Inhaler (bronchodilator) if wheezing 7. Student must be transported to the emergency department even if symptoms resolve for observation and further treatment.

MEDICATION

Medication	Dose	Side Effects
Epinephrine: ☐ Yes ☐ No	☐ 0.15 mg IM ☐ 0.3 mg IM	
Antihistamine:		
Other: (e.g., inhaler)		

PRESCRIBER TO COMPLETE

The above-named student is under my care and has the medical diagnosis of allergies. The information contained in this document reflects my plan of care for the above-named student.

☐ **It is medically appropriate** for the student to self-carry Epinephrine Auto Injector (EAI) medication. The student should be in possession of EAI medication and supplies at all times.

- ☐ Student can self-carry and self-administer EAI if needed, when able and appropriate.
- ☐ Student can self-carry, but **NOT** self-administer EAI.

☐ It is **NOT medically appropriate** to carry and self-administer this EAI medication. Please have the appropriate designated school personnel maintain this student's medication for use in an emergency.

☐ Additional Orders:

Prescriber Name:	**Phone:**
Prescriber Signature:	**Date:**

PARENT TO COMPLETE (Parent must sign in both places)

PARENT RESPONSIBILITIES

1. The parent/guardian is to furnish the Epinephrine Auto Injector (EAI) medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.
2. The parent/guardian, or other designated adult will deliver to the school and replace the Epinephrine Auto Injector (EAI) medication within two weeks if the Epinephrine Auto Injector (EAI) single dose medication is given.
3. If a student has a change in his/her prescription the parent/guardian is responsible for providing the newly prescribed information and dosing information as described above to the school. The parent/guardian will complete an updated Epinephrine Auto Injector Medication Authorization and Self-Administration Form (this form) before the designated staff can administer the updated Epinephrine Auto Injector (EAI) medication prescription.

PARENT/GUARDIAN AUTHORIZATION (Parent must sign in both places)
Checked boxes must match Health Care Provider Orders above

☐ **I authorize** my child to carry the prescribed medication described above. My student is responsible for, and capable of, possessing an Epinephrine Auto Injector per UCA 26-41-104. My child and I understand there are serious consequences for sharing any medication with others.	☐ **I authorize** my student to self-carry and self-administer EAI if needed, when able and appropriate. ☐ **I authorize** my student to self-carry, but **NOT** self-administer EAI.

☐ **I DO NOT authorize** my child to carry and self-administer this medication. Please have the appropriate designated school personnel to maintain my child's medication for use in an emergency.

Parent Signature:	**Date:**

As parent/guardian of the above-named student, I give my permission to the District Nurse and other designated staff to administer medication and follow protocol as identified in this Emergency Care Plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with allergy/anaphylaxis treatment, provided the personnel are following prescriber instruction as written in the emergency action plan above. Only staff trained by the school nurse for the current school year have been delegated to provide cares. Parent/guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider and the District Nurse if necessary for allergy management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent to notify District Nurse whenever there is any change in the student's health status or care. **This authorization order is effective for one year from licensed medical provider's signature date or earlier stop date of _____. This document is not valid and no specific accommodations will be made until signed by all parties.**

Parent Signature:		**Date:**
Emergency Contact Name:	**Relationship:**	**Phone:**

SCHOOL NURSE (or school office staff, health aide)

☐ Signed by PCP and parent ☐ Medication is appropriately labeled ☐ Medication Log Generated

EAI is kept: ☐ Student Carries ☐ Front Office ☐ Backpack ☐ Other:

This health care plan is to be distributed via PowerSchool or as needed by the front office to all "need to know" staff.

School Nurse Signature:	Date: