

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) – refer to their asthma care plan

NO

◇ STEP 1: TREATMENT ◇

SEVERE SYMPTOMS: Any of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Swelling of the tongue and/or lips
- HEART: Pale, blue, faint, weak pulse, dizzy
- SKIN: Many hives over body, widespread redness
- GUT: Vomiting or diarrhea (if severe or combined with other symptoms)
- OTHER: Feeling something bad is about to happen, Confusion, agitation



1. **INJECT EPINEPHRINE IMMEDIATELY**
 2. Call 911
 - Ask for ambulance with epinephrine
 - Tell EMS when epinephrine was given
 3. Stay with child and
 - Call parent/guardian and school nurse
 - If symptoms don't improve or worsen give second dose of epi if available as instructed below
 - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side
- Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinephrine. **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

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



1. Stay with child and
 - Alert parent and school nurse
 - Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and 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 if available

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: _____

◇ STEP 2: EMERGENCY CALLS ◇

1. If epinephrine given, call **911**. State that an anaphylactic 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) _____

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 and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

To be completed by healthcare provider

Permission To Administer Medication in Child Care / School

(one form per medication)

➤ To be completed by the child's health care provider with prescriptive authority:

CHILD _____ Birthdate _____

Medication _____

Dose _____ Route _____

Time of day medication is to be given _____

Special Instructions _____

Reason for medication _____

Possible Side Effects _____

START DATE _____ END DATE _____

Signature of Person with Prescriptive Authority _____ License Number _____

Print Name _____

Phone _____

Date _____

➤ To be completed by the parent or guardian

I hereby give my permission for _____
(Child's name)

to take the above medication in this center, as ordered by the health care provider.

I understand it is my responsibility to furnish this medication. I give permission for this information to be used in my child's facility, and for the person administering the medicine or nurse consultant to contact the above named physician by phone, fax, or in writing when necessary.

Parent / Guardian Name _____

Signature _____

Home Phone _____

Work phone _____

- The medication is to be brought in the original container which clearly states the child's name, the name of the medication, date, time, and dosage. If a prescription, it *also* needs to have the pharmacy name and phone number, licensed health care provider's name, and date medicine is to be stopped.
- This form must be filled out completely in order for the medication to be given. This is a Division of Early Care & Learning Licensing requirement (R&R 7.702.62C).