CGCSC Life-Threatening Allergy Emergency Action Plan (EAP) and Treatment Authorization (To be completed by Healthcare Provider)

Student Picture

School to provide

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No **Weight:** ____lbs.

Any SEVERE SYMPTOMS after suspected or known ingestion:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, diarrhea, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

- Call 911
- Begin monitoring (see below)
- Give additional medications:*
  - -Antihistamine
  - -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are **not** to be depended upon to treat a severe reaction (anaphylaxis). Use Epinephrine*

***When in doubt, use epinephrine**. Symptoms can rapidly become more severe**

MILD SYMPTOMS ONLY

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent.

IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

☐ If checked, give epinephrine for ANY symptoms if the allergen was ***likely*** eaten.
☐ If checked, give epinephrine before symptoms if the allergen was ***definitely*** eaten.

Medications/Doses

Epinephrine (BRAND and DOSE): _____

Antihistamine (BRAND and DOSE): _____

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

☐ Student may self-carry epinephrine ☐ Student may self-administer epinephrine

MONITORING: Stay with child. Tell EMS staff time epinephrine was given. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat student even if parents cannot be reached.

CONTACTS: Parent/Guardian: _____Ph:_____ _____

Name/ Relationship: _____Ph:_____ _____

Name/ Relationship: _____Ph:_____ _____

Licensed Healthcare Provider Signature: _____ Ph:_____ Date:_____
(Required)

I hereby authorize the CGCSC staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child for the implementation of this plan.

Parent/Guardian Signature: _____ Date: _____

DOCUMENTATION:

- Gather accurate information about the reaction, including who assisted in the medical intervention and who witnessed the event.
- Save food eaten before the reaction, place in a plastic zipper bag and freeze for analysis.
- If food was provided by school cafeteria, review food labels with cafeteria manager and Food Services Director.
- Follow-up:
  - Review facts about the reaction with the student and parents to provide the facts to those who witnessed the reaction or are involved with the student, on a need-to-know basis. Explanations will be age-appropriate.
  - Amend the Emergency Action Plan (EAP), Individual Health Care Plan (IHCP) and/or 504 Plan as needed.
  - Specify any changes to prevent another reaction.

TRAINED STAFF MEMBERS:

Name: _____ Location/Room: _____

Name: _____ Location/Room: _____

Name: _____ Location/Room: _____

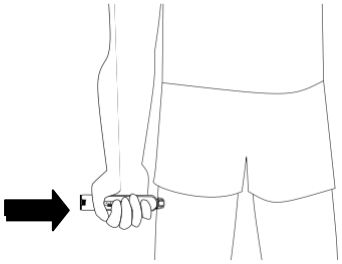
Name: _____ Location/Room: _____

Location of Medication: ☐Clinic ☐Student carries ☐Other:_____

EPIPEN Auto Injector and EPIPEN Jr Auto Injector Directions

- First, remove the EPIPEN Auto Injector from the plastic carrying case
- Pull off the blue safety release cap

- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.
  Remove the EPIPEN Auto Injector and massage the area for 10 more seconds

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions

Remove **GREY** caps labeled "1" and "2"

Place **RED** rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, and then remove

Twinject 0.3mg Directions

Remove **GREEN** caps labeled "1" and "2"

Place **RED** rounded tip against outer thigh, press down hard.
Hold for 10 seconds, and then remove

See instructions for 2nd dose, if needed

A food allergy response kit should contain at least one dose of epinephrine, other medications as noted by the student's physician, and a copy of this Allergy Emergency Action Plan. A kit must accompany the student if he/she is off school grounds (i.e., field trip)