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**FOOD/INSECT EMERGENCY ANAPHYLAXIS CARE PLAN and MEDICATION AUTHORIZATION**

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| Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician's assistant, and for interscholastic and intramural sports only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a qualified school personnel to administer medication.  |

**School:**

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| **STUDENT INFORMATION** | **Student Name**  | **DOB:** |
| **Home/Cell Phone**  | **Grade** |
| **KNOWN LIFE-THREATENING ALLERGIES:** ☐**PEANUTS** ☐ **TREE NUTS** ☐ **MILK** ☐**SOY** ☐ **WHEAT** ☐**SHELLFISH** ☐**FISH (OTHER)**☐ **BEE STINGS** ☐**LATEX** ☐ **EGGS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ☐ **OTHER:** **Confirmed with allergy testing ☐ yes ☐ no** | **History of Asthma?** ☐ No ☐ Yes (Increases risk of severe reaction)**Severe Anaphylactic Reaction? ☐ Yes,****☐** This child has an extreme severe allergy. Give Epinephrine immediately if allergen was ***likely*** eaten, at onset of ***any*** symptoms and follow the protocol below. |
| **KNOWN ORAL ALLERGY SYNDROME:** ☐ **No** ☐**Yes (list):**-------------------------------------------------------------------------------------------------------------------- |
| ➣ Provide separate medication authorization if treatment indicated |

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| **TREATMENT PLAN** | **AFTER EXPOSURE TO KNOWN OR SUSPECTED ALLERGY****& ANY OF THESE SYMPTOMS:****AIRWAY:** Difficulty breathing, swallowing, chest tightness, wheeze**THROAT:** Tight, hoarse, swollen tongue, difficulty swallowing/drooling**CARDIAC:** Dizzy, faint, confused, pale or blue, hypotension, weak pulse **&/OR****ANY COMBINATION OF SYMPTOMS FROM DIFFERENT BODY AREAS:*** Swollen lips, repetitive cough, sneezing, profuse runny nose
* Hives, itching (anywhere), swelling (e.g., eyes)
* Nausea, Vomiting, diarrhea, crampy pain
 |  | **follow this protocol:****1.** **INJECT EPINEPHRINE IMMEDIATELY!**2. Call 9113. Lie down if able, avoid rapid upright positioning & continue monitoring4. Give additional medications as ordered - Antihistamine  - Bronchodilator/Albuterol if has asthma5. Notify Parent/Guardian6. Notify Prescribing Provider / PCP7. When indicated, assist student to rise  very slowly. |

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| **EPINEPHRINE** | ☐ Epinephrine Auto-injector, Jr (0.15mg) IM side of thigh ☐ Epinephrine Auto-injector (0.3mg) IM side of thigh * **A second dose** of epinephrine can be given 5 minutes or more if symptoms persist or recur.

**Relevant Side Effects** ☐ Tachycardia☐ Other**: Medication Allergies** ☐ NKDA☐ Other: |
| Medication shall be administered during school year: |  **to**  | **NOTE:** if nurse is not available, the epinephrine autoinjector may be given by designated school personnel with exposure or for any anaphylaxis symptoms |

**TO BE COMPLETED BY PARENT AND AUTHORIZED HEALTHCARE PROVIDER: REQUIRED**

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| **AUTHOR****I****ZAT****ION** | * *Confirms student is capable of carrying medication***☐** **Yes ☐ No**
* *Confirms student is capable to safely and properly administer medication***☐** **Yes ☐ No**

**If a child refuses/is unable to self-treat, a trained personnel must be available and able to administer medication****Prescriber’s Signature: Date** | **Date**:      **Prescriber’s printed name or stamp** |
| **Parent:** I hereby request that the above ordered medication be administered by school personnel and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. This protocol will be in effect until the end of the current or extended school year. This medication will be destroyed if not picked up within one week following termination of the order or the end of the school year. Whichever comes first, unless the student will be attending an extended school year (ESY) program. A new protocol will be needed for the next school year. I have received, reviewed and understand the above information. |
| **Parent’s Signature:**  | **Date** |