**Potential for altered respiratory status/anaphylaxis**

- **www.foodallergy.org**

**School District**

**Allergy to** ________

- **Emergency Contact**
  - **Parent/Guardian**
    - **Health Care Provider Name/Title**

**AUTHORIZATION**

- **MEDICATION ORDER**
  - **TREATMENT PLAN**

**FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:**

- **LUNG:** Short of breath, wheezing, repetitive cough
- **HEART:** Dizzy, faint, confused, pale, blue, weak pulse
- **THROAT:** Tight, hoarse, trouble breathing/swallowing, drooling
- **MOUTH:** Swelling of tongue, lips
- **SKIN:** Many hives over body, widespread redness over body
- **GUT:** Nausea, repetitive vomiting, severe diarrhea, cramping
- **Other:** Feeling something bad is about to happen, anxiety, confusion

**OR A combination of mild symptoms from different body areas**

**MILD ALLERGY SYMPTOMS:**

- **MOUTH:** Itchy mouth, lips, tongue and/or throat
- **SKIN:** A few hives, itchy skin
- **NOSE:** Itchy/runny nose, sneezing
- **GUT:** Mild nausea/discomfort

**FOLLOW THIS PROTOCOL:**

1. **INJECT EPINEPHRINE IMMEDIATELY!**
   - (Note time)
2. **CALL 911.** Request ambulance with epinephrine.
   - Don’t hang up & don’t leave student
   - Give additional medications as ordered
     - [Antihistamine (if ordered below)]
     - [Inhaler (Albuterol) if student has asthma]
   - Lay student flat and raise legs. If breathing is difficult or vomiting, sit up or lie on their side
   - Notify School Nurse and Parent/Guardian
   - When indicated, assist student to rise slowly
   - Student must be transported to ER

**THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL SYMPTOMS OF ANAPHYLAXIS CAN POTENTIALLY PROGRESS TO A LIFE THREATENING SITUATION!!**

**Epinephrine**

- **Epinephrine (0.15mg) inject intramuscularly**
  - Epi Pen
  - Auvi Q
  - Adrenaclick
- **Epinephrine (0.3mg) inject intramuscularly**
  - Epi Pen
  - Auvi Q
  - Adrenaclick

A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.

**MEDICATION ORDER**

- **Antihistamine**
  - Do not depend on antihistamines or inhalers.
  - When in doubt, give epinephrine and call 911.

- **Benadryl/Diphenhydramine**
  - Dose: ______mg.
  - Route: PO

- **Other**
  - Dose: ______mg
  - Route:

**Note:** If School Nurse is not available, the above treatment plan may be provided by trained school personnel for any anaphylaxis symptoms.

**MUST BE COMPLETED BY PARENT AND AUTHORIZED HEALTH CARE PROVIDER**

- **Prescriber’s Signature:** ___________________________ Date: __________
- **Printed Name:** ___________________________ Phone: __________

**Authorization**

- **Parent/Guardian Consent:** I have received, reviewed and understand the above information. I approve of this Allergy Action Plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary. I assume full responsibility for providing the school with the prescribed medications. I give my permission for the school to share the above information with school staff that need to know about my child’s condition.

- **Parent/Guardian Signature:** ___________________________ Date: __________

**School Nurse:**

- I have reviewed this order and completed the Allergy Emergency Care Plan and have trained school personnel.

- **Signature / Date**

- **Medication Expires on:** __________

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- **Allergy Action Plan**
  - **Goal:** Patent Airway