ALLERGY & ANAPHYLAXIS - EMERGENCY ACTION PLAN (EAP)

Allergy Medication Authorization & Epinephrine Auto-Injector Authorization (EAI) Self-Administration Form

Utah Department of Health, In Accordance with UCA 26-41-104

School Year:

STUDENT INFORMATION

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

Student:	DOB:	Grade:	School:
Parent:	Phone:		Email:
Physician:	Phone:		Fax or email:
School Nurse:	School Phone:		Fax or email:

EXTREMELY REACTIVE TO THE FOLLOWING:

Allergen(s):

☐ 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.

☐ peanuts	☐ wheat	☐ latex	☐ other (specify):
☐ tree nuts	☐ eggs (safe to have in baked goods)	☐ animals	
☐ soy	☐ dairy (safe to have in baked goods)	☐ medication	
☐ fish	☐ dairy (NOT safe to have in baked goods)	☐ insect stings (specify):	
☐ shellfish	☐ eggs (NOT safe to have baked goods)		

ACTIONS FOR MILD TO MODERATE ALLERGIC REACTION

MILD Symptoms
Nose – itchy/runny nose
Mouth- Itchy mouth
Skin – A few hives, mild itch
Gut – Mild nausea/discomfort, one episode of mild vomiting (not repetitive)

For MILD SYMPTOMS from A SINGLE SYSTEM area, follow the directions below:

- Antihistamines 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 MILD SYMPTOMS from MORE THAN ONE system area, GIVE EPINEPHRINE

ACTION FOR SEVERE ALLERGIC REACTION (ANAPHYLAXIS)

SEVERE Symptoms
Lung-short of breath, wheezing, repetitive cough
Heart-pale, blue, faint, weak pulse, dizzy
Throat-tight, hoarse, trouble breathing or swallowing
Mouth-significant swelling of the tongue and/or lips
Skin-Many hives over body, widespread redness
Gut-Repetitive vomiting, severe diarrhea
Other-Feeling something bad is about to happen, anxiety, confusion

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. Call 911. Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
3. Consider giving additional medications <u>following epinephrine</u>
   - Antihistamine
   - Inhaler (bronchodilator) if wheezing
4. 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.
5. If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
6. Alert emergency contacts.
7. Transport them to emergency department even if symptoms resolve. Person should remain in ED for at least 4 hours because symptoms may return.

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Student Name:		**DOB:**
MEDICATION		
Epinephrine (EAI) Brand:	Epinephrine Dose: ☐0.15 mg IM ☐0.3 mg IM	Side Effects:
Antihistamine Name:	Dose:	Side Effects:
Other: (e.g., inhaler-bronchodilator of wheezing)	Other Dose:	Side Effects:
☐Student Carries ☐Backpack ☐In Classroom ☐ Health Office ☐ Front Office ☐ Other (specify):		

PRESCRIBER TO COMPLETE

The above named student is under my care. The above 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.

Prescriber Name:	Phone:
Prescriber Signature:	Date:

PARENT TO COMPLETE

Parental Responsibilities:

• The parent or 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.

• The parent or 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.

• If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dosing information as described above to the school. The parent or guardian will complete an updated Epinephrine Auto Injector (EAI) Authorization Form/Emergency Action Plan (this form) before the designated staff can administer the updated Epinephrine Auto Injector (EAI) medication prescription.

Parent/Guardian Authorization	
☐ **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 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 school 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 physician instruction as written in the emergency action plan above. Parent/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers 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/guardian to notify school staff whenever there is any change in the student's health status or care.

Parent Name (print):	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:

SCHOOL NURSE (or principal designee if no school nurse)

☐ Signed by physician and parent	☐ Medication is appropriately labeled	☐ Medication Log generated

EAI is kept: ☐Student Carries ☐Backpack ☐Classroom ☐ Health Office ☐ Front Office ☐ Other (specify):

Allergy & Anaphylaxis EAP distributed to 'need to know' staff:
☐ Front office/administration ☐ PE teacher(s) ☐ Teacher(s) ☐ Transportation ☐ Other (specify):

School Nurse Signature:	Date: