## ALLERGY MEDICAL MANAGEMENT PLAN (to be used only if epinephrine is needed at school)

(MUST be FILLED OUT COMPLETELY by PHYSICIAN/HEALTHCARE PROVIDER)

**Name**: _____ **D.O.B.**: _____ **School Yr.** _____
Parent: _____ Primary Phone No. _____
Physician: _____ Phone: _____
**Allergic to:** _____
If food allergy: _____
Asthma □ Yes □ No (Higher risk for severe reaction if asthmatic)
**Location(s) where Epinephrine/Rescue Medicine is/are stored**: □ Backpack □ Teacher □ on person □ Med must go with student if he/she is off school grounds (i.e. band or field trips, sporting events etc.) □ Other _____

**PLACE I.D. PHOTO HERE**

**SEVERE ALLERGY TO**: _____
□ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
□ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

**Any SEVERE SYMPTOMS after suspected or known ingestion and/or exposure**:

**One or more of the following**:

LUNG: Shortness 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

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring* (see box below)
4. Give additional medications**
   -Antihistamine
   -Inhaler (bronchodilator) if asthmatic

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

**MILD SYMPTOMS ONLY**:

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

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring* (see box below)

### MEDICATIONS

**Epinephrine:** inject intramuscularly □ EpiPen® 0.3 mg □ EpiPen® Jr. 0.15 mg □ Twinject™ 0.3 mg □ Twinject™ 0.15 mg
□ Adrenaclick® 0.3 mg □ Adrenaclick® 0.15 mg □ Other _____ Child may self- administer epinephrine: □ Yes □ No
**Antihistamine**: give _____
Other: (e.g. inhaler/bronchodilator if asthmatic) _____
**For Self Administration of EpiPen auto injector (4th grade or older):**
□ It is my professional opinion that _____ □ should □ should NOT carry and use the EpiPen by his/herself.

**Monitoring***
*Stay with student: alert healthcare professionals and parent*. Tell rescue squad epinephrine was given: request an ambulance with epinephrine. Note time when epinephrine was administered**. A second dose of epinephrine can be given 5 minutes or more after the first,** if symptoms persist or recur. For severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.

Authorization for Healthcare Provider and School Nurse to Share Information: I authorize my child's school nurse to assess my child in regards to his/her special healthcare needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____
(Required)
Signature below indicates that the plan is reviewed and appropriate documentation is complete

School Nurse Signature _____ Date_____