School Emergency Allergy Plan: Food or Insect

This protocol is in effect until the end of the current school year unless renewed and initialed by provider

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL as stated *in accordance with CT State Law and Regulations 10-212a*

Student Name _____ DOB _____ History of Asthma Yes No

Home Phone _____ Work Phone _____ Cell _____

Health Care Provider Name(s) _____ Phone

Food or Insect Allergen(s)	History of Anaphylaxis	History of Oral Allergy Syndrome	Date of Allergy Testing
	Yes No	Yes No	
	Yes No	Yes No	
	Yes No	Yes No	

- **Notify provider if treatment received**
- **Administer bronchodilator after epi-pen if student has a history of asthma**
- **Call 911 for ED evaluation if Epi Pen administered** (Side Effects include tachycardia, tremors nausea, dizziness, anxiety)

Potential Life-Threatening Allergen(s)

ANAPHYLAXIS MANAGEMENT

IF STUDENT INGESTS / IS STUNG OR IS THOUGHT TO HAVE BEEN EXPOSED TO THE FOLLOWING:

1. Observe student for symptoms of anaphylaxis*
2. Administer Epi Pen IM for ***any*** symptoms of anaphylaxis: 0.15Mg 0.3Mg
   - Prescriber authorization to self-administer Yes No
     - *Confirms student is capable to safely and properly administer medication*
3. Administer PO Benadryl (Diphenhydramine) 25mg 50mg (Side Effects include drowsiness, dizziness, dry mouth)

☐Do not Administer Benadryl Other: _____

ORAL ALLERGY SYNDROME (OAS) MANAGEMENT

IF STUDENT INGESTS OR IS THOUGHT TO HAVE BEEN EXPOSED TO THE FOLLOWING & SYMPTOMS ARE LIMITED TO THE LIPS, MOUTH, AND TONGUE:

1. Administer Benadryl (Diphenhydramine) 25mg 50mg

☐ Do not Administer Benadryl Other: _____

2. Observe student for progressing symptoms of anaphylaxis*
3. Administer Epi Pen IM for ***any additional*** symptoms of anaphylaxis: 0.15Mg 0.3Mg
   - Prescriber authorization to self-administer Yes No
     - *Confirms student is capable to safely and properly administer medication*

Known Oral Allergy Syndrome Allergen(s)

_____ Date Renewed/Initials _____
Date Health Care Provider Signature Date Renewed/Initials _____

_____
Stamp or Printed Name

Parent/Guardian: I have reviewed and agree with the above medication administration protocol. I authorize communication between the prescribing health care provider and school nurse necessary for the safe implementation of this treatment protocol as long as it is in effect.

_____
Date Parent/Guardian Signature

Parent/Guardian authorization to self-administer medication Yes No

_____
Date Parent/Guardian Signature

***Symptoms of LIFE-THREATENING anaphylaxis:**

Usually occurs within minutes, but may occur up to 2 hours after exposure

- Facial, lips, tongue swelling
- Chest tightness, wheezing, cough, shortness of breath
- Dizziness, fainting, "feeling of impending doom"
- Itchy skin, hives
- Difficulty swallowing, tightness in throat
- Abd cramping, nausea, vomiting