

MCPS Anaphylaxis Action Plan: Individual Student

Student Name: _____

Grade: _____

Date of Birth: _____

ALLERGY TO: _____

Weight: _____ lbs.

Asthma

Yes (greater risk of severe reaction)

No

Extremely reactive to the following:

THEREFORE:

If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten/ student stung, as applicable.

If checked, give epinephrine immediately if the allergen was definitely eaten/student stung even if NO symptoms ARE NOTED.

IF NEITHER OF THE ABOVE CHECKED, THEN FOLLOW THE INSTRUCTIONS AS WRITTEN BELOW.

Note: Do not depend on antihistamine or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE & CALL 911!

For a suspected or active allergic reaction:

FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS

- LUNG: Short of breath, wheeze, repetitive cough, chest tightness, blue skin and/or lip color
 - HEART: pale, blue, faint, weak pulse, dizzy, or confused
 - THROAT: Tightness, hoarse, trouble breathing or swallowing
 - MOUTH: Swelling of tongue, lips or back of throat
 - SKIN: Widespread redness or hives, or eye swelling
 - GUT: Repetitive vomiting, severe diarrhea, or abdominal cramps
 - OTHER: Feeling of doom, confusion or loss of consciousness
 - OR A combo of symptoms from different body areas
1. **INJECT EPINEPHRINE IMMEDIATELY!!!**
 2. **CALL 911. Request ambulance with epinephrine.**
 3. Consider additional medications after epinephrine if ordered.
 4. Antihistamine
 5. Inhaler (bronchodilator) if wheezing
 6. Monitor student. Note time Epi was given. Lay student flat with legs elevated. If difficulty breathing or vomiting sit or turn on side.
 7. Give second dose of epinephrine in 5 minutes or more after the 1st dose if symptoms do not improve or reoccur.
 8. Call parent and school nurse (see back for contact numbers).
 9. Student should be transported to the ER even if symptoms resolve and remain in ER for 4+ hours because symptoms may return.

For mild symptoms:

- NOSE: Itchy/ runny nose, sneezing

- MOUTH: Itchy mouth
- SKIN: Few hives, mild itch
- GUT: Mild nausea or discomfort

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTION BELOW:

1. Give antihistamines if ordered below
2. Stay with student
3. Contact parent and school nurse (see back page)
4. Monitor student closely for changes.
- 5. IF SYMPTOMS WORSEN, GIVE EPINEPHIRNE**

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPRHINE

MEDICATIONS/DOSES

Epinephrine Auto-Injector: See back for administration directions for student’s brand

Epinephrine Dose:

0.15 mg IM

0.3 mg IM

Antihistamine

Type: _____

Dose: _____

Other medication or inhaler.

Type: _____

Dose: _____

Student may carry medication AND self-medicate without supervision. As the medical provider, I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication on their own without school personnel supervision. Student must report immediately to an adult/school staff.

Student may not self-medicate without supervision.

Healthcare Provider Signature and Information

Healthcare Provider Signature: _____

Date: _____ (valid for 12 months)

Printed Healthcare Provider Name: _____

Phone number: _____

Parent Section

1. NOTICE TO PARENT/GUARDIAN: Please Sign

The school district may have “stock” epinephrine according to Section 20-5-420, MCA and School Board Policy 3416.

Epinephrine supplied by the district, where and when available, is NOT intended to take the place of parent supplied epinephrine or student carried epinephrine. Epinephrine, supplied by parent and given to the school or carried by the student, should be available for off campus activities or after school activities. This is the responsibility of the parent/guardian.

I agree to doctor (health care provider) and school nurse communication based on this medical order/permission if needed. Communication, if needed, may only include the medication or treatment itself, implementation of the treatment in school and student outcomes of the treatment.

Parent Signature: _____

Date: _____

For students who carry and/or self-administer medications: Authorization by parent, individual who has executed a caretaker relative educational or medical authorization affidavit, or guardian: See generally Mont. Code Ann. § 20-5-420. As the parent, individual who has executed a caretaker relative educational or medical authorization affidavit, or guardian of the above named student, I confirm this student has been instructed by his/her healthcare provider on the proper use of this/these medication(s). He/she has demonstrated to me he/she understands the proper use of this medication. He/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self-medicate as listed above, if needed. If he/she has used epinephrine during school hours, he/she understands the need to alert the school nurse or other adult at the school who will provide follow-up care, including making a 9-1-1 emergency call.

- I acknowledge the school district or nonpublic school and its employees and agents are not liable as a result of any injury arising from the self-administration of medication by the student, and I indemnify and hold them harmless for such injury, unless the claim is based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.
- I agree to work with the school in establishing a plan for use and storage of any backup medication. This will include a predetermined location to keep backup medication to which the student has access in the event of an asthma, severe allergy, or anaphylaxis emergency.
- I understand in the event the medication dosage is altered, a new "self-administration form" must be completed, or the health care provider may rewrite the order on his/her prescription pad and I, the parent/caretaker relative/guardian, will sign the new form and assure the new order is attached.
- I understand it is my responsibility to pick up any unused medication at the end of the school year, and any medication not picked up may be disposed of.
- I authorize the school administration to release this information to appropriate school personnel and classroom teachers.

Parent Signature: _____

Date: _____

Form adapted May 2018 from Food Allergy Action Plan 4/17, [Food Allergy Website](#) Food Allergy Research and Education (FARE).