ST JOHN REGIONAL CATHOLIC SCHOOL

AUTHORIZATION FOR MANAGEMENT OF ANAPHYLAXIS

This order is valid only for the current school year.

*911 will be called while the student, health staff or school staff administers the epinephrine.

Name: __________________________ Date of Birth: _______ Grade: _______

HEALTH CARE PROVIDER AUTHORIZATION

Administer Medication for the Following Allergen(s):
☐ insect sting/bite: __________________________    ☐ ingestion of: __________________________    ☐ contact with: __________________________
☐ unknown etiology (specify signs/symptoms): __________________________

Administer the Following Medication(s) Immediately:
☐ Epinephrine only
☐ Epinephrine and then adjunct medication(s)
☐ Adjunct medication(s) if no signs or symptoms are present:
   - Call parent/guardian to pick up student from school and to follow up with HCP.
   - Proceed with epinephrine if 1 or more of the following signs/symptoms is seen:
     - LUNG: difficulty breathing, repetitive/hacking cough, audible wheezing
     - THROAT: itching and/or tightness of throat, difficulty swallowing
     - MOUTH/FACE: swelling and/or tinging of lips, tongue, mouth; swelling of eyes
     - SKIN: many hives over the body
     - GUT: diarrhea, stomach pain and/or cramping, vomiting
   * A second dose of epinephrine will be administered in 5-10 minutes if EMS has not arrived.

**NOTE: Parent/guardian must provide a second dose of epinephrine.

Medication(s) Ordered:

<table>
<thead>
<tr>
<th>Epinephrine:</th>
<th>single dose auto-injector only</th>
<th>IM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.15 mg</td>
<td></td>
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<tr>
<td></td>
<td>0.30 mg</td>
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<table>
<thead>
<tr>
<th>Adjunct Medication(s):</th>
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<tbody>
<tr>
<td>☐ Diphenhydramine</td>
<td>☐ 12.5 mg</td>
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<tr>
<td></td>
<td>☐ 25 mg</td>
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<tr>
<td></td>
<td>50 mg</td>
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<tr>
<td>Other</td>
<td></td>
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☐ Student is competent to self-carry emergency medications
☐ Student is competent to self-administer emergency medications

Possible Medication Side Effects:
- Epinephrine: palpitations, rapid heart rate, sweating, nausea and vomiting
- Antihistamine: drowsiness, sedation, sleepiness, dizziness, restlessness, hypotension, palpitations
- Other: __________________________

Health Care Provider’s Name/Title: (please print) __________________________

Health Care Provider’s Signature: __________________________ Date: _______

PARENT/GUARDIAN AUTHORIZATION

I request designated personnel to administer the medication as prescribed by the health care provider above. I certify that I have legal authority to consent to the administration of medication at school and understand that the health care provider will be contacted if questions arise regarding the student’s medication order.

Primary Contact Phone: _______  2nd Phone: _______

Parent/Guardian Signature: __________________________ Date: _______

REGISTERED NURSE REVIEW / AUTHORIZATION

☐ Student is competent to self-carry emergency medications
☐ Student is competent to self-administer emergency medications

Registered Nurse Signature: __________________________ Date: _______
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _______________________________ D.O.B.: __________________________

Allergy to: ____________________________

Weight: ___________________ lbs. Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: ____________________________

THEFORE:
[ ] 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.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS

- LUNG
  Short of breath, wheezing, repetitive cough

- HEART
  Pale, blue, faint, weak pulse, dizzy

- THROAT
  Tight, hoarse, trouble breathing/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

OR A COMBINATION of symptoms from different body areas.

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

MILD SYMPTOMS

- NOSE
  Itchy/runny nose, sneezing

- MOUTH
  Itchy mouth

- SKIN
  A few hives, mild itch

- GUT
  Mild nausea/discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

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

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: ____________________________

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: ____________________________

Antihistamine Dose: ____________________________

Other (e.g., inhaler-bronchodilator if wheezing): ____________________________

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

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