SEVERE ALLERGY TREATMENT ORDERS

Saint Joseph School, Brookfield, CT 06804

Name of child_____ Grade_____DOB_____
Severely allergic to: _____

PRESCRIBER'S ORDER: If child is exposed to, ingests, or is stung, follow the selected treatment plan (A or B)

PLAN A:

_____ MD's Initials

Immediately administer epinephrine (adrenaline) by intramuscular injection to outer thigh, **without waiting** to see whether or not signs or symptoms of an allergic reaction occur. Call 911 for transport to Emergency Room. Administer an antihistamine by mouth.

►□ Epinephrine (EpiPen Jr) 0.15mg intramuscularly □ Epinephrine (EpiPen) 0.3mg intramuscularly
►□ Antihistamine: _____dose: _____by mouth

OR

PLAN B:

_____ MD's Initials

Administer an antihistamine by mouth, observe the patient for signs or symptoms of allergy for one hour. If signs or symptoms of allergy occur, administer epinephrine by injection and call 911 for transport to ER.
► Antihistamine: _____ dose: _____ by mouth

► **If signs or symptoms of allergic response occur, administer epinephrine:**
► □ Epinephrine (EpiPens Jr) 0.15mg intramuscularly □ Epinephrine (EpiPen) 0.3mg intramuscularly

IMPORTANT: On field trips in the absence of a nurse or the child's parent Plan A will be followed.

*SIGNS AND SYMPTOMS OF AN ALLERGIC REACTION INCLUDE:

Mouth	itching & swelling of lips, tongue
Throat	itching of throat, sense of tightness in the throat, hoarseness, difficulty swallowing
Skin	hives, itchy rash, swelling of face or extremities
Gut	nausea, abdominal cramps, vomiting, diarrhea
Lung	shortness of breath, repetitive coughing, wheezing, chest tightness
Cardiovascular	dizziness, faintness, loss of consciousness

Medication to be administered from (dates) _____to_____
Relevant side effects: _____

Prescriber's Stamp

Prescriber's authorization for self-carry and administration (student has been instructed in and understands the purpose and method of administration of epinephrine): □ yes □ no

Authorized Prescriber's Signature: _____Date _____
Authorized Prescriber's Name (printed): _____ Telephone: _____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION BY SCHOOL PERSONNEL

To: School Personnel
I hereby request that the above medication, ordered by the MD, DDS, OD, APRN or PAC for my child, be administered by school personnel. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. I understand that this medication will be destroyed (per state regulation) if it is not picked up by the last day of the school. *I am aware that during a class trip if a nurse or myself is not present Plan A will be used*. An adult must deliver medication to the school nurse.

Parent/Guardian authorization for self-carry and administration (student has been instructed in and understands the purpose and method of administration of epinephrine): □ yes □ no

Signature: _____ Relationship to child: _____ Date: _____
Name: (print) _____Telephone: (H) _____ (W) _____

Nurse: Student demonstrates knowledge of self-carry and administration: □ yes □ no _____
Nurse's signature and date