Wallingford Schools
Anaphylaxis/Allergy Treatment Plan: Food, Insect or Latex

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician's assistant and for interscholastic and intramural sports only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, qualified school personnel to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist. **All medication must be delivered by a responsible adult.**

Student Name _____DOB_____ **History of Asthma** Yes No

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	

Medication orders are good for school year and summer program 20____ to 20_____

ANAPHYLAXIS MANAGEMENT: IF STUDENT INGESTS OR IS THOUGHT TO HAVE BEEN EXPOSED TO THE ALLERGEN
CHECK APPROPRIATE BOX

☐ Administer epinephrine IM ***before*** symptoms occur **Jr** (0.15mg)_____ **Adult**(0.30mg)_____

OR

☐ Administer epinephrine IM for ***any*** symptoms of anaphylaxis **Jr** (0.15mg IM)_____ **Adult**(0.30mg)_____

2. Administer PO Benadryl, 25mg 50mg **(Circle One)**
3. Administer bronchodilator after epi-pen if student has a history of asthma Yes No **(circle one) (need order)**
4. Other/:_____

Call 911 for transport and evaluation to emergency department if Epinephrine administered

ORAL ALLERGY SYNDROME (OAS) MANAGEMENT: IF STUDENT INGESTS OR IS THOUGHT TO HAVE BEEN EXPOSED TO THE ALLERGEN ***& SYMPTOMS ARE LIMITED TO THE LIPS, MOUTH, AND TONGUE:***

1. Administer Benadryl, PO 25mg 50mg Other_____ , SWISH, GARGLE AND SWALLOW
2. Administer epinephrine IM **for *any* progression of symptoms to anaphylaxis Jr**(0.15mg)____**Adult**(0.3mg)____
3. Other/:_____
4. **Call 911 for transport and evaluation to emergency department if Epinephrine administered**
5. **For field trips or no nurse in school in a school, if any symptoms may administer epinephrine first(circle one) YES or NO**

Prescriber authorization to self-administer epinephrine **(circle one)** Yes No
Student demonstrates knowledge of self-administration **(circle one)** Yes **No**

_____ _____ _____
Health Care Provider Signature Date **Stamp or Printed Name** **Phone Number**

Parent/Guardian: I have reviewed and agree with the above 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.

_____
Parent/Guardian Signature Date

Parent/Guardian authorization to self-administer medication Yes No

_____
Parent/Guardian Signature Date

*****School nurse or designee to fax 911 report to primary care provider if epinephrine administered**

REV. 1/14