

**RUTHERFORD COUNTY SCHOOLS ANAPHYLAXIS ACTION PLAN AND MEDICATION ORDERS**

|   |                   |
|---|-------------------|
| <b>PARENT/GUARDIAN – complete top portion and sign at the bottom of form.</b> |                   |
| Name:   | Date of Birth:    |
| Grade:  | Teacher/Homeroom: |
| Parent/Guardian:  | Preferred Phone:  |
| 1 <sup>st</sup> Emergency Contact Name/Relationship:                          |                   |
| 1 <sup>st</sup> Emergency Contact Phone:                                      | Other Phone:      |
| 2 <sup>nd</sup> Emergency Contact Name/Relationship:                          |                   |
| 2 <sup>nd</sup> Emergency Contact Phone:                                      | Other Phone:      |



**ANAPHYLACTIC ALLERGY TO:** \_\_\_\_\_

**OTHER ALLERGIES:** \_\_\_\_\_

Location of student’s epinephrine: \_\_\_\_\_

**ASTHMA:**  NO;  YES (*higher risk for severe reaction*) and has self-carry permission on-file  Yes,  No

**Health Care Provider:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**◆ STEP 1 – TREATMENT ◆**

**SEVERE SYMPTOMS:** Any of the following:  
**LUNG:** Short of breath, wheeze, 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, confusion



**1. INJECT EPINEPHRINE IMMEDIATELY**  
**2.** Call 911 and activate school emergency response team.  
**3.** Call parent/guardian and school nurse  
**4.** Monitor student; keep them lying down  
**5.** Administer Inhaler (quick relief) if ordered  
**6.** Be prepared to administer 2<sup>nd</sup> dose of epinephrine if needed.  
 \*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe food related reaction. **USE EPINEPHRINE!**

**MILD SYMPTOMS ONLY:**  
**NOSE:** Itchy, runny nose, sneezing  
**SKIN:** A few hives, mild itch  
**GUT:** Mild nausea/discomfort



**1.** Alert parent and school nurse.  
**2.** Antihistamines may be given if ordered by a healthcare provider.  
**3.** Continue to observe student.  
**4.** If symptoms progress **USE EPINEPHRINE.**  
**5.** Follow directions in above box.

**Epinephrine Dose:** inject intramuscularly using auto injector (check one):  0.3 mg OR  0.15 mg

If symptoms do not improve after \_\_\_\_\_ minutes, or if symptoms return, 2<sup>nd</sup> dose of epinephrine should be given:  0.3 mg OR  0.15 mg

**Antihistamine:** (brand and dose): \_\_\_\_\_

**Asthma Rescue Inhaler:** (name and dose) \_\_\_\_\_ Has inhaler self-carry authorization on file.  Yes  No

- Student is capable of carrying his/her own epinephrine.  Yes  No
- Student has been instructed and is capable of self-administering his/her own epinephrine.  Yes  No

Provider’s Name (printed): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Provider’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**◆ STEP 2 - EMERGENCY CALLS ◆**

**1) If epinephrine is given, call 911. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.**

**2) Contact Parent/Guardian or emergency contacts as above.**

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the health care provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child’s health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Rutherford County School System, the undersigned parent or guardian hereby understands and agrees that the Rutherford County School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication. I, the undersigned parent or guardian hereby understand and agree that the Rutherford County School System and its personnel shall not be liable for any injury resulting from the student’s self-administration of the anaphylaxis medication, if applicable per health care provider’s selection above, while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct. (T.C.A. § 49-5-415)

**By signing, parent indicates agreement with the plan of action as described by health care provider.**

\_\_\_\_\_  
PARENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SCHOOL NURSE SIGNATURE

\_\_\_\_\_  
DATE

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Staff Members trained to administer anaphylaxis medications:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

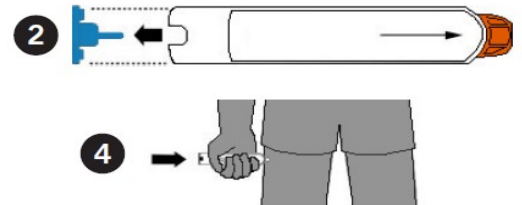
Room/Location

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\*\* Directions are different for each type of injector. READ INSTRUCTIONS FOR EACH. \*\*\***

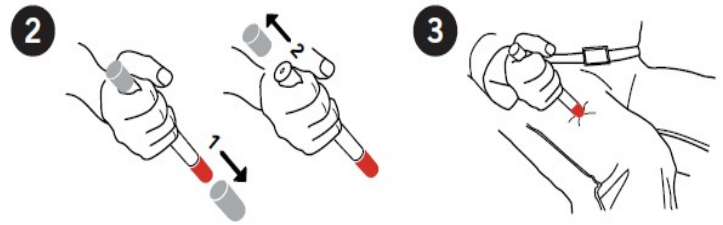
### EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



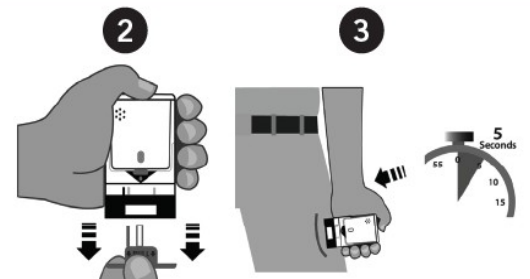
### ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.



### AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



**NOTE: Consider lying student on his/her back with legs elevated. Alternative positioning may be needed: side-lying or head to side for vomiting or sitting upright for any difficulty breathing.**

Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_