PHYSICIAN'S ORDER AND EMERGENCY CARE PLAN FOR ANAPHYLAXIS

Student_____Birthdate_____ **2022-2023 School Year**

Physician to complete

Identified life-threatening allergen(s) are:_____

Student has demonstrated use to LHCP and may self-administer the Epinephrine Auto-Injector: ☐ Yes ☐ No

Physicians order for epinephrine auto-injector ☐ 0.15mg ☐ 0.3mg

Repeat dose in 10 minutes if symptoms persist and EMS has not arrived ☐ Yes ☐ No

Student has asthma (high risk for severe reaction) ☐ Yes ☐ No Inhaler_____Dose:_____Puffs

1. Administer auto-injector if student is unable or not authorized to self-administer **for suspected or actual exposure to above noted life-threatening allergen(s)**
2. Call 911
3. If other medication is prescribed administer as ordered.

If epinephrine auto-injector is not immediately available, call 911.

Symptoms of anaphylaxis may include:	
Gastrointestinal:	*Nausea, stomachache, abdominal cramps, vomiting, diarrhea*
Heart:	*Passing out, fainting, pale or bluish skin color*
Lung:	*Shortness of breath, repetitive coughing, wheezing*
Mouth:	*Itching, tingling, or swelling of the lips, tongue or mouth*
Skin:	*Hives, itchy rash, swelling about the face or extremities*
Throat:	*Sense of tightness in the throat, hoarseness, hacking cough*
General:	*Panic, sudden fatigue, chills, fear*
Other:	*Some students may experience symptoms other than those listed above*

Medication Authorization: Health Care Provider and Parent/Legal Guardian signatures required: I request and authorize that the above-named student be administered the above identified medication in accordance with the instructions indicated above for a potentially life-threatening condition. I understand that **trained unlicensed school personnel** may be delegated to administer the emergency epinephrine auto-injector. By signing this I consent to exchange of information regarding this medication authorization between the school and the health care provider. I have read and understand the information on page 2 of this form.

Health Care Provider Signature_____ Date_____

Health Care Provider Name_____ Phone Number_____

Parent/Guardian Signature_____ Date_____

PARENT/GUARDIAN INFORMATION REGARDING MEDICATIONS IN SCHOOL

I certify that I am the parent, legal guardian, or other person in legal control of this student. I request and authorize the school to administer the medication prescribed, as authorized by RCW 28.A210.260-270 and RCW 18.71.030 (3). This includes oral, inhaled, topical, nasal, rectal, eye and ear drops that shall be given at school **only when absolutely necessary**. Designated/trained employees shall administer this medication in compliance with Licensed Health Care Provider (LHCP) orders.

I understand the medication must be furnished in the **current, original container** from the pharmacy with the student's name, the name of the medication and the amount to be given. Non-prescription medication must be furnished in the original container from the manufacturer. All medication must be in a form ready to be administered and **must not** require any preparation by building staff. If the dosage or time should change, new orders and container will be provided.

I understand it is **my** responsibility to deliver and maintain an adequate supply of the medication at school.

I understand medication orders are only valid for the current school year (including summer school). Any medication remaining at the end of the school year, not picked up immediately after the last day of school, will be disposed, with the exception of Extended School Year students.

If self-administration is requested (and approved by principal/nurse), I certify that my child has the skill level necessary to do so, and that the school will assume no responsibility/liability for the administration of the medication or its use. Student may only carry a one day supply of oral medication.

ASTHMA ACTION PLAN

☐ **Intermittent** has symptoms of wheezing and coughing no more than 2 days a week, with nighttime flare-ups twice a month or less. Outside to these few episodes, a student is free of symptoms.

☐ **Mild** Symptoms occur more than twice a week but less than once a day, flare-ups may affect activity.

☐ **Moderate** Symptoms occur daily, flare-ups usually last several days. Symptoms disrupt normal activities and make it difficult to sleep.

☐ **Severe** Symptoms occur daily and often, also curtail the student's activities and disrupt sleep.

WARNING SIGNS OF AN ASTHMA ATTACK:	EMERGENCY RESCUE PLAN:
• Constant cough • Difficulty breathing with struggling or gasping for breath, or an audible wheeze with breathing • Stooped body posture • Trouble walking or talking, or stops playing and can't start activity again • Lips or fingernails are grey or blue (light complexion only) • _____	• Remove student from known triggers, if possible. • Accompany student to health room • Give medication as prescribed: • Keep student sitting up and reassure student • Encourage student to drink warm fluids
No improvement 15-20 minutes after initial treatment with medication.	• Notify parent. • Call school nurse • If parents are unable to come within 10 min call 911
If student is in severe distress	**Call 911.** Notify parent, principal and school nurse.