

New Mexico Allergy Action Plan and Medication Authorization

School District / School Name: _____ School Year: _____

Student Name: _____	Date of Birth: _____ School ID#: _____
Parent/Guardian: _____	Contact phone number: _____
Other Emergency Contact: _____	Emergency Contact phone number: _____
Allergist/Provider name: _____	Allergist/Provider phone number: _____

Allergy: _____ History of severe anaphylactic reaction: ☐ Yes ☐ No

☐ If food allergy, provide documentation for school nutrition services per district policy if applicable.

Asthma ☐ Yes (higher risk of severe reaction) ☐ No

If student is experiencing MILD Symptoms:

SKIN: a few hives, mild itch, lip swelling NOSE: itchy, runny nose, sneezing GUT: mild nausea, discomfort, single vomit		1. Stay with student and give antihistamine as ordered below 2. If two or more mild symptoms present or symptoms progress GIVE EPINEPHRINE and follow directions below
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If student is experiencing SEVERE Symptoms:

LUNGS: Shortness of breath, wheeze, coughing MOUTH: Visible swelling of the tongue THROAT: Tight, hoarse, trouble swallowing SKIN: Many hives over body, widespread red/purple/gray color HEART: Faint, weak pulse, dizzy, pale, blue/gray skin, lips, nails GUT: Ongoing vomiting or diarrhea OTHER: Feeling something bad is about to happen, confused/agitated		1. GIVE EPINEPHRINE right away and note the time when it is given. Stay with the student. 2. Call 911/EMS and stay on the line with them  If student is still having trouble breathing, throat symptoms, heart symptoms, vomiting, has become unresponsive or even less alert or loss of consciousness: GIVE SECOND DOSE OF EPINEPHRINE (if available) For heart symptoms or 2 doses of epinephrine given, lay student on back with legs raised. If breathing difficulty or vomiting have them sit up or lie on side.
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MEDICATION ORDERS and PROVIDER AUTHORIZATION

Epinephrine: <u>Auto-injector</u> ☐ 0.1 mg ☐ 0.15 mg ☐ 0.3 mg (inject intramuscularly) <u>Nasal Spray:</u> ☐ 1 mg ☐ 2 mg (1 spray to nostril) <i>A second dose of epinephrine can be given 5 minutes or more after first dose if symptoms persist, recur, or worsen.</i>	Antihistamine: <u>Cetirizine</u> Dose: _____ mg Route: _____	Other Medication: (including inhaler) Medication Name: _____ Instructions: _____ Medication Name: _____ Instructions: _____
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Prescriber Signature: _____ **Date:** _____

If applicable: *I confirm student is capable to safely carry and properly administer above medication* ☐ Yes ☐ No

Parent/Guardian and School Nurse Authorizations

Parent/Guardian Consent: I have received, reviewed and understand the above information. I approve of this Allergy Action Plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary. I assume full responsibility for providing the school with the prescribed medications. I give my permission for the school to share the above information with school staff that need to know about my child's condition.	
Parent/Guardian Signature: _____	Date: _____
If applicable: <i>I confirm my child is capable to safely carry and properly administer above medication</i> ☐ Yes ☐ No	
School Nurse: I have reviewed this order and completed the allergy emergency care plan and shared with trained school staff.	
School Nurse Signature: _____	Date: _____

Potential for altered respiratory status/anaphylaxis

Goal: Patent Airway