ALLERGY & ANAPHYLAXIS - EMERGENCY ACTION PLAN (EAP)

Allergy Medication Authorization & Epinephrine Auto-Injector Authorization (EAI)
Self-Administration Form
Utah Department of Health/OSD, In Accordance with UCA 26-41-104

School Year:

Picture

STUDENT INFORMATION

Asthma: ☐ No ☐ Yes (if yes, high risk for severe reaction, please also complete Asthma Action Plan)

Student:	DOB:	Grade:	School:
Parent:	Phone:	Email:	
Physician:	Phone:	Fax:	
School Nurse:	Phone:	Fax:	

EXTREMELY REACTIVE TO THE FOLLOWING:

Allergen(s):

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

☐ peanuts	☐ wheat	☐ latex	☐ other (specify):
☐ tree nuts	☐ eggs (safe to have in baked goods)	☐ animals	
☐ soy	☐ dairy (safe to have in baked goods)	☐ medication	
☐ fish	☐ dairy (NOT safe to have in baked goods)	☐ insect stings (specify):	
☐ shellfish	☐ eggs (NOT safe to have baked goods)		

ACTIONS FOR *MILD* TO MODERATE ALLERGIC REACTION

MILD *Symptoms*

Nose – Itchy/runny nose

Mouth- Itchy mouth

Skin – A few hives, mild itch

Gut – Mild nausea/discomfort, one episode of mild vomiting (not repetitive)

For MILD SYMPTOMS from A SINGLE SYSTEM area, follow the directions below:

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine.

For MILD SYMPTOMS from MORE THAN ONE system area, GIVE EPINEPHRINE

ACTION FOR *SEVERE* ALLERGIC REACTION (ANAPHYLAXIS)

SEVERE Symptoms

Lung-short of breath, wheezing, repetitive cough

Heart-pale, blue, faint, weak pulse, dizzy

Throat-tight, hoarse, trouble breathing or 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, anxiety, confusion

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. Call 911. Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
3. Consider giving additional medications following epinephrine
   - Antihistamine
   - Inhaler (bronchodilator) if wheezing
4. Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
5. If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
6. Alert emergency contacts.
7. Transport them to emergency department even if symptoms resolve. Person should remain in ED for at least 4 hours because symptoms may return.

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Student Name:		**DOB:**
MEDICATION ***PRESCRIBER TO COMPLETE***		
Epinephrine (EAI) Brand:	Epinephrine Dose: ☐0.15 mg IM ☐0.3 mg IM	Side Effects:
Antihistamine Name:	Dose:	Side Effects:
Other: (e.g., inhaler-bronchodilator of wheezing)	Other Dose:	Side Effects:

PRESCRIBER TO COMPLETE

The above named student is under my care. The above reflects my plan of care for the above named student.

☐ **It is** medically appropriate for the student to self-carry Epinephrine Auto Injector (EAI) medication. The student should be in possession of EA medication and supplies at all times.

☐ Student can self-carry and self-administer EAI if needed, when able and appropriate.

☐ Student can self-carry, but not self-administer EAI.

☐ **It is not** medically appropriate to carry and self-administer this EAI medication. Please have the appropriate/designated school personnel maintain this student's medication for use in an emergency.

Prescriber Name:	**Phone:**
Prescriber Signature:	**Date:**

PARENT TO COMPLETE

Parental Responsibilities:

• The parent or guardian is to furnish the Epinephrine Auto Injector (EAI) medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.

• The parent or guardian, or other designated adult will deliver to the school and replace the Epinephrine Auto Injector (EAI) medication within two weeks if the Epinephrine Auto Injector (EAI) single dose medication is given.

• If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dosing information as described above to the school. The parent or guardian will complete an updated Epinephrine Auto Injector (EAI) Authorization Form/Emergency Action Plan (this form) before the designated staff can administer the updated Epinephrine Auto Injector (EAI) medication prescription.

Parent/Guardian Authorization

☐ **I authorize** my child to carry the prescribed medication described above. My student is responsible for, and capable of, possessing an epinephrine auto-injector per UCA 26-41-104. My child and I understand there are serious consequences for sharing any medication with others.

☐ I authorize my student to self-carry and self-administer EAI if needed, when able and appropriate.

☐ I authorize my student to self-carry, but not self-administer EAI.

☐ **I do not authorize** my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency.

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in this Emergency Care Plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with allergy/anaphylaxis treatment, provided the personnel are following physician instructions as written in the emergency action plan above. Parent/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for allergy management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.

Parent Name (print):	**Signature:**	**Date:**
Emergency Contact Name:	**Relationship:**	**Phone:**
SCHOOL NURSE		
☐ Signed by physician and parent	☐ Medication is appropriately labeled	☐ Medication Log generated

EAI is kept: ☐Student Carries ☐Backpack ☐Classroom ☐ Health Office ☐ Front Office ☐ Other (specify):

Allergy & Anaphylaxis EAP distributed to 'need to know' staff:
☐ Front office/administration ☐ PE teacher(s) ☐ Teacher(s) ☐ Transportation ☐ Other (specify):

Medical Statement to Request Special Meals, Accommodations, Milk Substitutions

1. Site Name (School/Sponsor):	2. Name of Parent/Guardian	3. Telephone Number
4. Name of Child *		5. Date of Birth

6. State the medical condition requiring accommodation.

This section must be completed by a licensed medical authority. Refer to the reverse side of this page for definitions.

7. Does the medical condition affect major life activities or major bodily functions? Select one of the following. *

☐ Yes, this condition affects major life activities or major bodily functions and qualifies as a disability.

☐ No, this condition does not affect major life activities or major bodily functions and does not qualify as a disability.

According to the ADA the term 'disability' means, with regards to an individual: a physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment. The USDA has adopted this definition of a disability in child nutrition programs.

8. Provide a brief description of the major life activity or bodily function affected by the disability. *

Consuming foods to be omitted may result in:

☐Nausea ☐ Vomiting ☐ Diarrhea ☐ Itching ☐ Swelling ☐ Rash ☐ Wheezing/Coughing ☐ Choking
☐ Other:

9. Describe diet prescription and/or accommodation. Must include specific foods to be omitted and substituted. *

Foods and/or beverages to be omitted:*	**Foods and/or beverages to be substituted:***

10. Modified texture (if applicable): ☐ Chopped ☐ Ground ☐ Puree

11. Adaptive Equipment Needed (if applicable):

12. Signature of Medical Authority & Credentials*	**13. Printed Name***	**14. Telephone Number**	**15. Date***

I give permission for the institution's personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate institution staff and to follow the prescribed diet order for my child's meals. I also give permission for my child's medical authority to further clarify the prescribed diet order on this form if requested to do so by institution personnel.

Signature of parent or guardian: Date:

***Required**

Medical Statement to Request Special Meals, Accommodations, Milk Substitutions

A licensed medical authority is defined as an individual who has the authority to write a medical prescription. In Utah, this includes:

- Medical Doctor (MD)
- Advance Practice Registered Nurses (APRN)
- Physician's Assistant (PA)
- Naturopathic Physicians (ND or NMD)
- Osteopathic Physicians (DO)

Definition of Disability
Under Section 504 of the Rehabilitation Act of 1073 and the Americans with Disabilities Act (ADA) A Person with a Disability is defined as: any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.
Physical or Mental Impairment-(a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genitor-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.
Major Life Activities-functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.
Major Bodily Functions- functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, and reproductive functions
Record of Impairment-having a history of or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities. Individuals who take mitigating measures to improve or control any of the conditions recognized as a disability, are still considered to have a disability and require an accommodation.

USDA Guidelines for Accommodating Special Dietary Needs
Disability-Institutions and agencies participating in federal nutrition programs must comply with requests for special dietary meals and any adaptive equipment with a documented disability and completed request form.
Non-disability-Institutions and agencies participating in federal nutrition programs may comply with requests for non-disabling medical conditions. Accommodations will be made on a case-by-case basis. However, if accommodations are made for a specific medical condition, complete requests for the same medical condition for other participants must be accommodated.
Fluid Milk Substitutions-Fluid milk substitutions apply to non-disability requests. Institutions and agencies participating in the federal nutrition program may accommodate complete requests with a USDA approved non-milk equivalent. If accommodations are made for one child requesting a fluid milk substitute, accommodations must be made for all children requesting a fluid milk substitute.

School/sponsor internal use only
☐ Marked as disability or treating as disability (Required to accommodate request.) ☐ Not marked as disability ☐ School/sponsor is accommodating request ☐ School/sponsor is not accommodating request
Signature/Date:

This institution is an equal opportunity provider