

# Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

School year 20\_\_\_\_ - 20 \_\_\_\_ C.R.S. 22-1-119.5 A treatment plan shall be effective only for the school year in which it is approved.

Student's name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Grade: \_\_\_\_\_  
 School: \_\_\_\_\_ Teacher/Classroom: \_\_\_\_\_  
 Allergy to: \_\_\_\_\_  
 History: \_\_\_\_\_

Place student's photo here

**To be completed by healthcare provider:**  
 Emergency-use epinephrine:  0.1 mg auto-injector  0.15 mg auto-injector  0.3 mg auto-injector  
 1 mg nasal spray  2 mg nasal spray  
 If symptoms worsen or do not improve in 5 minutes, or if symptoms return, give 2nd dose of epinephrine, if available.  
 Antihistamine (if prescribed) medication, dose, route, frequency: \_\_\_\_\_  
 Asthma?  No  Yes - If yes, be aware of higher risk for severe reaction.  
 Self-administer?  No  Yes - If yes, student has been instructed and is capable of carrying and self-administering own emergency-use epinephrine medication. Note: A trained staff member must be available to administer in the event the student is unable to self-administer for any reason.

If you see this:	Do this:
<b>Green zone: normal activities - no symptoms</b>	
<ul style="list-style-type: none"> <li>Student may participate in all normal activities.</li> </ul>	<ol style="list-style-type: none"> <li>Continue to avoid known allergens.</li> <li>Ensure emergency medications are readily available.</li> </ol>
<b>Yellow zone: mild symptoms</b>	
Affecting <b>one</b> body system only: <ul style="list-style-type: none"> <li><b>Nose:</b> Itchy, runny nose, sneezing</li> <li><b>Skin:</b> A few hives, mild itch</li> <li><b>Gut:</b> Mild nausea/discomfort</li> </ul>	<ol style="list-style-type: none"> <li>Stay with student.</li> <li>Give antihistamine (if prescribed above).</li> <li>Alert parent/guardian and school nurse.</li> <li><b>⚠ If symptoms spread to a second body system, immediately move to red zone.</b></li> <li>Continue to monitor closely.</li> </ol>
<b>Red zone: severe symptoms</b>	
<b>Two or more</b> body systems with mild symptoms or any severe symptoms in <b>one</b> or more body systems: <ul style="list-style-type: none"> <li><b>Lung:</b> Short of breath, wheezing, repetitive cough</li> <li><b>Throat:</b> Tight, hoarse, trouble breathing/swallowing</li> <li><b>Mouth:</b> Swelling of the tongue and/or lips</li> <li><b>Heart:</b> Pale, blue, faint, weak pulse, dizzy</li> <li><b>Skin:</b> Many hives over body, widespread</li> <li><b>Gut:</b> Vomiting or diarrhea (if combined with other symptoms)</li> <li><b>Other:</b> Feeling something bad is about to happen, confusion, agitation</li> </ul>	<ol style="list-style-type: none"> <li><b>Give epinephrine immediately!</b></li> <li><b>Call 911!</b> <ul style="list-style-type: none"> <li>Tell 911 dispatch that epinephrine was given.</li> <li>Tell EMS what time epinephrine was given.</li> </ul> </li> <li>Stay with student and:                             <ul style="list-style-type: none"> <li>Monitor student, keeping them lying on their back; if vomiting or difficulty breathing, put student on their side.</li> <li>Call parent/guardian and school nurse.</li> </ul> </li> <li>Give 2<sup>nd</sup> dose if symptoms worsen or do not improve, or if symptoms return, as ordered above (if available).</li> <li>Give other prescribed medications after administering epinephrine (if available).</li> </ol> <p><b>⚠ Important: Do not hesitate to administer epinephrine.</b>                      Key principle: If allergic reaction affects <b>two</b> body systems, give epinephrine as a first-line treatment.</p>

Healthcare provider name (print): \_\_\_\_\_ Phone number: \_\_\_\_\_

Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/guardian name (print): \_\_\_\_\_ Phone number: \_\_\_\_\_

Parent's/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

School nurse signature: \_\_\_\_\_ Date: \_\_\_\_\_

For the school nurse: Self-carry contract on file?  No  Yes Meal modification form?  No  Yes

