Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

Student's Name: _____ D.O.B. _____ Grade: _____

School: _____ Teacher: _____

ALLERGY TO: _____

HISTORY: _____

Place child's photo here

Asthma: ☐ YES (higher risk for severe reaction) – refer to their asthma care plan
☐ NO

To be completed by healthcare provider

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:
- LUNG: Short of breath, wheeze, repetitive cough
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Swelling of the tongue and/or lips
- HEART: Pale, blue, faint, weak pulse, dizzy
- SKIN: Many hives over body, widespread redness
- GUT: Vomiting or diarrhea (if severe or combined with other symptoms
- OTHER: Feeling something bad is about to happen, Confusion, agitation

→

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
   - Ask for ambulance with epinephrine
   - Tell EMS when epinephrine was given
3. Stay with child and
   - Call parent/guardian and school nurse
   - If symptoms don't improve or worsen give second dose of epi if available as instructed below
   - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinphrine. **USE EPINEPHRINE**

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

→

1. Stay with child and
   - Alert parent and school nurse
   - Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and follow directions in above box

DOSAGE: Epinephrine: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve ____ minutes or more, or symptoms return, 2nd dose of epinephrine should be given if available

Antihistamine: (brand and dose)_____

Asthma Rescue Inhaler (brand and dose)_____

Student has been instructed and is capable of carrying and self-administering own medication. ☐Yes ☐No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an anaphylactic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: _____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. _____ 1) _____ 2) _____
   b. _____ 1) _____ 2) _____

DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

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's Signature: _____ Date: _____

School Nurse: _____ Date: _____

Student Name: _____ DOB: _____

Staff trained and delegated to administer emergency medications in this plan:

1._____ Room _____

2._____ Room _____

3._____ Room _____

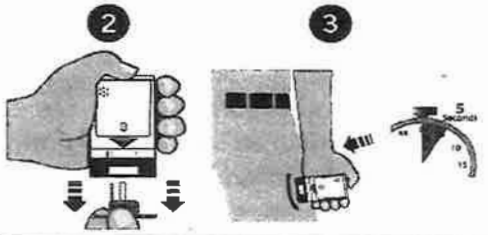
Self-carry contract on file: ☐Yes ☐No

Expiration date of epinephrine auto injector: _____

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.

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.

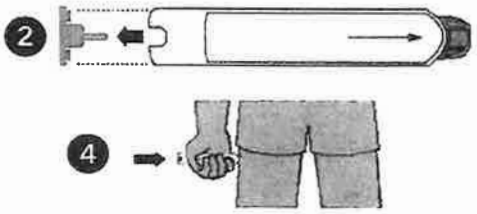


ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

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.

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.



If this conditions warrents meal accomodations from food service, please complete the form for dietary disabilitiy if required by district policy.

Additional information:_____

_____

_____

_____

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017

Inhaler Technique Assessment Tool

Name_____

Inhaler device **(Check one):** MDI alone (≥ 5 yrs old) MDI plus spacer MDI plus spacer with mask

Instructions. Give one point for each step performed correctly (1=Yes, correct technique). Provide a reason for why a step was not done correctly for steps with a score of 0. For boxes with a score of 0, provide more teaching or coaching in these areas until a total score of 5 is obtained. Record the number of attempts until a satisfactory technique is obtained in the column "Coaching".

Sequence of Critical Steps & Criteria		Scoring Circle 1 or 0		Coaching
1) Removes Cap				
Score 1 if:	Score 0 if:	**1**	**0**	
✓ **MDI**: Removes cap from mouthpiece. ✓ **MDI plus spacer** (with or without mask): Remove cap(s) AND correctly inserts MDI into spacer. ✓ Checks counter (if applicable)	☐ Did not remove cap(s). ☐ Incorrect MDI insertion into spacer. ☐ Metal canister not in plastic mouthpiece correctly. ☐ Other:			
2) Correctly primes device				
Score 1 if:	Score 0 if:	**1**	**0**	
✓ Shakes the MDI inhaler AND inhaler is upright.	☐ Forgot to shake. ☐ Device held incorrectly (e.g., upside down). ☐ Other:			
3) Exhales				
Score 1 if:	Score 0 if:	**1**	**0**	
✓ Exhales completely or breathes out to the end of a normal breath before putting device in mouth. ✓ MDI plus spacer with mask: Step above plus ensure good fit of mask (nose and mouth should be covered).	☐ Does not exhale fully. ☐ MDI plus spacer with mask: Nose and mouth not covered with a good seal. ☐ Other:			
4) Inhales appropriately for device				
Score 1 if:	Score 0 if:	**1**	**0**	
✓ **MDI**: Positioned in mouth or 2-3 finger breadths away from mouth. At the same time starts to breathe in slowly to full inspiration, depresses the inhaler to release 1 puff of medicine. Position with chin up. Inspiration should be 30L/min or 3-5 seconds. ✓ **MDI plus spacer**: Places mouthpiece of spacer into the mouth, with lips closed tightly around it to get a good seal, presses the inhaler once. Breathes in slowly through the mouthpiece (30L/min or 3-5 secs). ✓ **MDI plus spacer with mask**: Once mask has good seal over nose and mouth, press inhaler once with slow tidal breathing (breathing in and out) for 3-5 breaths.	☐ Not a good seal between the mouth and mouthpiece/facemask. ☐ Can't synchronize breathing in with puff. (MDI alone) ☐ Head not correctly positioned. ☐ Spray blocked by teeth or tongue. ☐ Breathing in too quickly. (With Aerochamber will hear a whistle) ☐ Inhales through nose. ☐ Delivers 2 sprays at once. ☐ Cough provoked by inhalation. ☐ Tidal breathing technique: Breathes in and out less than 3-5 breaths per dose. ☐ Other:			
5) Holds breath				
Score 1 if:	Score 0 if:	**1**	**0**	
✓ Holds breath to count of 10. ✓ Lips kept closed while holding breath. ✓ Waits 30-60 seconds before repeating process.	☐ Breath held for less than 10 seconds. ☐ Other			

Provider:	**Date:**	**TOTAL SCORE:**

Developed by L Cicutto RN, PhD revised 8/2011

Asthma Control

Student Code: _____ Date: _____

In the past two weeks, how often have you:	Well Controlled	Not Well Controlled	Poorly Controlled
- felt asthma symptoms, such as trouble breathing, coughing or wheezing (a whistling sound in the chest)? 	0-2 days per week	3-7 days per week	Everyday, more than once per day
- woken up at night because of asthma? 	None	1-2 times	3 or more times
- used your rescue inhaler to relieve asthma symptoms?* 	0-2 days per week	3-7 days per week	Several times a day
- decreased your activity (exercise,sports, play) or missed school because of asthma?	None	Sometimes	Often or a lot

This school year, have you needed to:		
- take oral steroids (prednisone)?	No	Yes
- go to the emergency room, Convenient Care Clinic, or provider for urgent care?	No	Yes
- stay overnight in the hospital?	No	Yes

* Rescue inhalers include: albuterol, MaxAir®, ProAir®, Proventil®, Ventolin® and Xopenex®.

COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS

PARENT/GUARDIAN COMPLETE AND SIGN:

School/grade: _____

Child Name: _____ Birthdate: _____

Parent/Guardian Name: _____ Phone: _____

Healthcare Provider Name: _____ Phone: _____

Triggers: ☐Weather (cold air, wind) ☐Illness ☐Exercise ☐Smoke ☐Dust ☐Pollen ☐Other: _____

☐Life threatening allergy, specify: _____

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child/youth, and if necessary, contact our healthcare provider. I assume full responsibility for providing the school/program prescribed medication and supplies, and to comply with board policies, if applicable. I am aware 911 may be called if a quick relief inhaler is not at school and my child/youth is experiencing symptoms. I approve this care plan for my child/youth.

PARENT SIGNATURE	DATE	NURSE/CCHC SIGNATURE	DATE

HEALTHCARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:	QUICK RELIEF (RESCUE) MEDICATION: ☐ Albuterol ☐ Other: _____ Common side effects: ↑ heart rate, tremor ☐ Have child use spacer with inhaler. Controller medication used at home: _____
IF YOU SEE THIS:	**DO THIS:**
GREEN ZONE: No Symptoms Pretreat • No current symptoms • Doing usual activities	Pretreat strenuous activity: ☐Not required ☐Routine ☐Student/Parent request Give QUICK RELIEF MED 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs ☐ Repeat in 4 hours, if needed for additional physical activity. ***If child is currently experiencing symptoms, follow YELLOW ZONE.***
YELLOW ZONE: Mild symptoms • Trouble breathing • Wheezing • Frequent cough • Complains of tight chest • Not able to do activities, but talking in complete sentences • Peak flow: _____ & _____	1. Stop physical activity. 2. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs 3. Stay with child/youth and maintain sitting position. 4. **REPEAT** QUICK RELIEF MED, if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs 5. Child/youth may go back to normal activities, once symptoms are relieved. 6. Notify parents/guardians and school nurse. ***If symptoms do not improve or worsen, follow RED ZONE.***
RED ZONE: EMERGENCY Severe Symptoms • Coughs constantly • Struggles to breathe • Trouble talking (only speaks 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips/fingernails gray or blue • ↓ Level of consciousness • Peak flow < _____	1. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs ▪ Refer to anaphylaxis plan, if child/youth has life-threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 4. Notify parents/guardians and school nurse. 5. If symptoms do not improve, **REPEAT** QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs every 5 minutes until EMS arrives. *School personnel should not drive student to hospital.*

PROVIDER INSTRUCTIONS FOR QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)

☐ Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.

☐ Student understands proper use of asthma medications, and in my opinion, can carry and use his/her inhaler at school independently with approval from school nurse and completion of contract.

☐ Student will notify school staff after using quick relief inhaler, if symptoms do not improve with use.

HEALTH CARE PROVIDER SIGNATURE	PRINT PROVIDER NAME	DATE	FAX	PHONE

Copies of plan provided to: ☐Teacher(s) ☐PhysEd/Coach ☐Principal ☐Main Office ☐Bus Driver Other_____

COLORADO Department of Education

Revised: March 2018