Emergency Action Plan and Order: Severe Allergy in School

Mecklenburg County Public Health

School Name	School Phone #	Fax:	For School Use Only
		(704) 432-2079 (School Health)	Date Received/Receiver's Signature: Medication Received? ❒ yes ❒ no
Student's Name (Please print.)	Student's Date of Birth		Date Approved/Nurse's Signature Entered in EHR? ❒ yes ❒ no
Parent/Guardian: Please read both pages of the Action Plan. Sign and date the bottom of both pages to show your agreement.			❒ Student Self Carries ❒ Medication in Health Room ❒ Medication in Classroom

Important Information about Medication Admininstration in CMS Schools

- When possible, medications should be taken before or after school. Administration of non-prescription medications at school is discouraged.
- Written parent/guardian consent and an order from a healthcare provider licensed in North Carolina are required for administering prescription and over-the-counter medications at school (CMS Policy JLCD/Regulation JLCD-R). Contact the school nurse for help if relocating from another state with orders from an out-of-state provider. Some medications may not be suitable for a school setting. Additional documentation may be required for some medications (examples: research medications, medications with potential for immediate serious side effects). Contact the school nurse if you have questions.
- Unless changed in writing, this plan will be used for the entire school year within which it was written.
- Medications are given by a nurse or trained CMS staff.
- No medication will be given at school until this authorization has been approved by a school nurse.
- New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. Parents/guardians must supply the medications.
- Each medication must be in the original labeled container from the pharmacy or healthcare provider's office. Some pharmacies will provide an extra container for school use.
- Information about this medication and the student's health may be shared with other school staff or agents of the school to help assure the student's safety and success at school.
- The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and the student's health.

Healthcare Provider's Name / Address / Phone / Fax (please print or use stamp)	Parent/Guardian Contact Information (please print)	
	Parent/Guardian	
	Phone:	Phone:
	Parent/Guardian	
	Phone:	Phone:

I have read and understand the "Important Information about Medication Administration in CMS Schools" in this action plan. I give permission for my child to receive the medications noted in this plan during school hours. I give permission for the healthcare provider, pharmacist and their staff to provide information to the school nurse about this medication and my child's health. On behalf of my child, I release the Charlotte-Mecklenburg Board of Education, their agents and employees from any and all liability whatsoever that may result from my child taking this medication at school.

Write on line below.

Parent's/Guardian's Name (print) Signature Date

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Student's Name:	Student's Date of Birth:

To be completed by student's health care provider: If student is approved to self-carry and/or self-medicate, also complete the identification section and Section 3 of the Medication Authorization for CMS Students (Med 1) form. Attach this form to the Medication Authorization form.

List student's allergies:

Some Signs/Symptoms of Severe Allergic Reaction:

- Trouble breathing
- Wheezing
- Hoarseness (changes in the way voice sounds)
- Hives (raised reddened rash that may itch)
- Severe itching
- Swelling of the face, lips, mouth, or tongue
- Skin rash, redness, or swelling
- Fast heartbeat
- Weak pulse
- Feeling very anxious
- Confusion
- Stomach pain
- Dizziness, fainting, or "passing out" (unconsciousness)
- Tightness in the chest or throat
- Difficulty swallowing, drooling, or slurred speech
- Tingling around the face or mouth

If ingestion of or contact with allergen is suspected <u>and/or</u> symptoms of a severe allergic reaction occur immediately give medication listed below.

Name of Medication	Dosage	Route	Possible Side Effects
Epinephrine	mg	Intramuscular (Anterolateral aspect of thigh)	
Diphenhydramine	mg	Oral	

If Epinephrine is given (e.g., Auvi-Q, Epinephrine Auto-Injector, EpiPen):

1. **Stay with the student. ■ Monitor alertness and breathing. ■ Provide CPR if necessary.**
2. **Have another person: ■ Call 911 immediately. ■ Notify school nurse, parent/guardian and principal.**
3. **If symptoms are getting worse or not improving after 5 minutes, administer a <u>one-time second dose</u> in the anterolateral aspect of the opposite thigh (not in the same thigh as the first dose).**

In my professional opinion, the medication noted above is necessary for this student if an allergic reaction occurs at school.		
Health Care Provider Name (print):		
Health Care Provider Signature:		Date:

I have reviewed this Emergency Action Plan and agree with this plan. I agree to school staff being trained to administer the medication.		
Preferred Hospital:		
Parent/Guardian Signature:		Date: