BROOKFIELD PUBLIC SCHOOLS

ALLERGY TREATMENT PROTOCOL

Student Name _____ Grade _____ Date of Birth _____

Allergen(s) for which drug(s) are being administered: _____

PRESCRIBER'S ORDER: IF CHILD IS EXPOSED TO, INGESTS, OR IS STUNG FOLLOW THE SELECTED TREATMENT PLAN (A or B):

PLAN A :

_____ **MD's Initials**

Immediately administer epinephrine (adrenaline) by intramuscular injection, **without waiting** to see whether or not signs or symptoms of an allergic reaction occur. Call 911 for transport to the emergency room. Administer an antihistamine by mouth.

☐ Epinephrine Jr. 0.15 mg intramuscularly ☐ Epinephrine 0.3 mg intramuscularly

AND OTC medication:

Antihistamine:_____ by mouth_____(dose)

OR

PLAN B :

_____ **MD's Initials**

Administer an antihistamine by mouth, observe the patient for signs or symptoms of allergy* for one hour. If signs or symptoms of allergy* occur administer epinephrine by injection and call 911 for transport to ER.

Antihistamine:_____ by mouth_____(dose)

***If signs or symptoms of allergy occur administer epinephrine:**

☐ Epinephrine Jr. 0.15mg intramuscularly ☐ Epinephrine 0.3mg intramuscularly

ON FIELD TRIPS OR IN THE ABSENCE OF A NURSE, PLAN (A) WILL BE FOLLOWED

***SIGNS AND SYMPTOMS OF AN ALLERGIC REACTION INCLUDE:**	
MOUTH	Itching & swelling of lips, tongue
THROAT	Itching of throat, sense of tightness in the throat, hoarseness, difficulty swallowing
SKIN	Hives, itchy rash, swelling of face or extremities
GUT	Nausea, abdominal cramps, vomiting, diarrhea
LUNG	Shortness of breath, repetitive coughing, wheezing, chest tightness
CARDIOVASCULAR	Dizziness, faintness, loss of consciousness

Medication to be administered from _____ to _____. Including overnight or extended day field trips, intramural and interscholastic events.
Relevant side effects: _____

Prescriber's Stamp

Prescriber's Authorization for Self Carry and Administration (student has been instructed in and understands the purpose and method of administration of epinephrine): ☐ Yes ☐ No

Authorized Prescriber's Signature: _____ Date: _____

Authorized Prescriber's Name (printed): _____ Telephone: _____

AUTHORIZATION BY PARENT/GUARDIAN:

I hereby request that the above medication, ordered by the MD, DDS, OD, APRN or PAC for my child be administered by school personnel. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. I understand that this medication will be destroyed (per State regulation) if it is not picked up by the last day of school. **AN ADULT MUST DELIVER MEDICATION TO SCHOOL NURSE.**

Any drug allergies? ☐ Yes ☐ No If yes, what? _____

Parent/Guardian Authorization for Self carry and Administration (student has been instructed in and understands the purpose and method of administration of epinephrine): ☐ Yes ☐ No

Signature: _____ Relationship to child: _____ Date: _____
Name: (print) _____Telephone: (H) _____(W) _____

Nurse: Student demonstrates knowledge of self carry and administration: ☐ Yes ☐ No_____
Nurse Signature/Date