

ALLERGY TREATMENT PROTOCOL

Name of child _____ Grade _____ Date of Birth _____

Condition for which drug(s) are being administered during school hours: _____

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.

[] Epipen Jr. 0.15mg intramuscularly [] Epipen 0.3mg intramuscularly

and administer antihistamine:

Diphenhydramine elixir (Benadryl) 12.5mg/5ml : Administer by mouth

Mark dosage: [] 12.5mg [] 25mg [] 50mg [] No antihistamine

Other _____

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 the emergency room.

Diphenhydramine elixir (Benadryl): 12.5mg/5ml : Administer by mouth

Mark dosage: [] 12.5mg [] 25mg [] 50mg

Other _____

* If signs or symptoms of allergy occur administer epinephrine

[] Epipen Jr. 0.15mg intramuscularly [] Epipen 0.3mg intramuscularly

*** SIGNS AND SYMPTOMS OF AN ALLERGIC REACTION INCLUDE:

Table with 2 columns: Body Part (Mouth, Throat, Skin, Gut, Lung, Cardiovascular) and Symptoms (itching & swelling of lips, tongue; itching of throat, sense of tightness in the throat, hoarseness, difficulty swallowing; hives, itchy rash, swelling of face or extremities; nausea, abdominal cramps, vomiting, diarrhea; shortness of breath, repetitive coughing, wheezing, chest tightness; dizziness, faintness, loss of consciousness)

Medication to be administered from _____ to _____.

Relevant side effects to be observed, if any: Epipen = jitters & tachycardia, Benadryl = sedation. If there are side effects, plan for management: Call physician if symptoms do not resolve spontaneously.

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

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION BY SCHOOL PERSONNEL

To: School Personnel

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 and will provide no more than a 45 school day supply of said medication. I understand that this medication will be destroyed if it is not picked up by the last day of the school.

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