Allergy and anaphylaxis Simplified individualized healthcare plan (IHP)/emergency action plan (EAP) Medication authorization and self-administration form In accordance with 26B-4-407 Utah Department of Health & Human Services/Utah State Board of Education	School year:	Picture

Student information			
Asthma: ☐ No ☐ Yes (if yes, high risk for severe reaction, please also complete asthma action plan)			
Student:	DOB:	Grade:	School:
Parent:	Phone:		Email:
Physician:	Phone:		Fax or email:
School nurse:	School phone:		Fax or email:
Medical diagnosis(es):	Age at diagnosis:		Confirmed by HCP? ☐ yes ☐ no

Allergen(s)	
Allergy to:	
☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms. ☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.	
Yellow: mild to moderate reaction	Action
MILD Symptoms • Itchy/runny nose • Itchy mouth • A few hives, mild itch • Mild nausea/discomfort	For MILD SYMPTOMS from A SINGLE SYSTEM area, follow the directions below: • Antihistamines may be given, if ordered by a healthcare provider. • Stay with the person; alert emergency contacts. • Watch closely for changes. If symptoms worsen, give epinephrine. For MORE THAN ONE symptom, GIVE EPINEPHRINE
Red: severe reaction	Action
SEVERE Symptoms • Short of breath, wheezing, repetitive cough • Skin color is pale, blue, • Faint, weak pulse, dizzy • Tight or hoarse throat, trouble breathing or swallowing • Significant swelling of the tongue and/or lips • Many hives over body, widespread redness • Repetitive vomiting, severe diarrhea • Feeling something bad is about to happen, anxiety, confusion	1. INJECT EPINEPHRINE IMMEDIATELY. 2. Call EMS. Tell them the student is having anaphylaxis and may need epinephrine when they arrive. 3. Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side. 4. Give second dose of epinephrine if symptoms get worse, continue, or do not get better in 5 minutes. 5. Alert emergency contacts. 6. Give other medication (only if prescribed). DO NOT use other medication in place of epinephrine. • Antihistamine • Inhaler (bronchodilator) if wheezing 7. Transport them to emergency department even if symptoms resolve. Person should remain in ED for at least 4 hours because symptoms may return.

Medication		
Medication brand	Dose	Side effects
Epinephrine:	☐ 0.15 mg IM ☐ 0.3 mg IM	
Antihistamine:		
Other: (e.g., inhaler-bronchodilator of wheezing)		

CONTINUED ON NEXT PAGE →

Student name:	DOB:	School year:

Prescriber to complete

The above-named student is under my care with a medical diagnosis of _____.
The above reflects my plan of care for the above-named student.

☐ It is medically appropriate for the student to self-carry epinephrine auto injector (EAI) medication. The student should be in possession of EAI medication and supplies at all times.
- ☐ Student can self-carry and self-administer EAI if needed, when able and appropriate.
- ☐ Student can self-carry, but not self-administer EAI.

☐ It is not medically appropriate to carry and self-administer this EAI medication. Please have the appropriate/designated school personnel maintain this student's medication for use in an emergency.
☐ Additional orders:

Prescriber name:	Phone:
Prescriber signature:	Date:

Parent to complete

Parental responsibilities:
• The parent or guardian is to furnish the epinephrine auto injector medication and bring to the school in the current original pharmacy container and pharmacy label with the student's name, medication name, administration time, medication dosage, and healthcare provider's name.
• The parent or guardian, or other designated adult will deliver to the school and replace the Epinephrine Auto Injector medication within two weeks if the epinephrine auto injector single dose medication is given.
• If a student has a change in their prescription, the parent or guardian is responsible for providing the newly prescribed information and dosing information as described above to the school. The parent or guardian will complete an updated epinephrine auto injector medication authorization and self-administration form (this form) before the designated staff can administer the updated epinephrine auto injector medication prescription.

Parent/guardian authorization
☐ I authorize my student to carry the prescribed medication described above. My student is responsible for, and capable of, possessing an epinephrine auto-injector per UCA 26B-4-407. My student and I understand there are serious consequences for sharing any medication with others.
- ☐ I authorize my student to self-carry and self-administer EAI if needed, when able and appropriate.
- ☐ I authorize my student to self-carry, but not self-administer EAI.

☐ I do not authorize my student to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my student's medication for use in an emergency.

Parent signature:	Date:

As parent/guardian of the above-named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in this emergency action plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand, or action, etc., against them for helping this student with allergy/anaphylaxis treatment, provided the personnel are following prescriber instruction as written in the emergency action plan above. Parent/guardians and students are responsible for maintaining necessary supplies, medication, and equipment. I give permission for communication between the prescribing health care provider and the school nurse if necessary for allergy management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.

Parent name (print):	Signature:	Date:
Emergency contact name:	Relationship:	Phone:

School nurse (or principal designee if no school nurse)

☐ Signed by prescriber and parent	☐ Medication is appropriately labeled	☐ Medication log generated

EAI is kept: ☐Student carries ☐Backpack ☐Classroom ☐ Health office ☐ Front office
☐ Other (specify):

Allergy & anaphylaxis EAP distributed to 'need to know' staff: ☐ Teacher(s) ☐ PE teacher(s)
☐ Transportation ☐ Front office/admin ☐Other (specify):

School nurse signature:	Date: