ALLERGY TREATMENT PROTOCOL

JCCGW Preschool 2015

Name of child_____ Class_____ 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 OTC medication:

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

Mark dosage: ☐ **12.5mg** ☐ **25mg** ☐ **50mg** ☐ **No antihistamine**

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 the emergency room.

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

Mark dosage: ☐ **12.5mg** ☐ **25mg** ☐ **50mg**

* **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:

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 _____.

Time of Administration: **See treatment plan above: CIRCLE PLAN A or B**

Relevant side effects to be observed, if any: Epi-pen=jitters & tachycardia, Benadryl=sedation.

If there are side effects, plan for management: Call physician if symptoms do not resolve spontaneously.

Physician's Signature: _____ Date _____

Physician'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) _____