

YOUR SCHOOL DISTRICT
ANAPHYLAXIS TREATMENT PLAN AND PHYSICIAN'S ORDER FORM

Student Name: _____	DOB: _____
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STUDENT ALLERGY HISTORY:

1. Has this student had an anaphylactic reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No				
2. What is this student allergic to?	<input type="checkbox"/> Dairy	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Soy	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Eggs	<input type="checkbox"/> Sesame	<input type="checkbox"/> Sting	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Fin Fish	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Tree Nuts	<input type="checkbox"/> Other: _____
3. Has the student and family been educated about the avoidance of the offending agent? <input type="checkbox"/> Yes <input type="checkbox"/> No				
4. Has the student and family been educated in the indications for EpiPen/EpiPen Jr administration, checking outdated medicine, and storing the EpiPen/EpiPen Jr? <input type="checkbox"/> Yes <input type="checkbox"/> No				
5. If insect bite, has student had venom testing? <input type="checkbox"/> Yes <input type="checkbox"/> No Has student been desensitized to the venom? <input type="checkbox"/> Yes <input type="checkbox"/> No				
6. Does student have a medical alert bracelet? <input type="checkbox"/> Yes <input type="checkbox"/> No				
7. In your opinion, is this student able to safely self-administer the EpiPen/EpiPen Jr? <input type="checkbox"/> Yes <input type="checkbox"/> No				

SCHOOL DISTRICT EPIPEN PROTOCOL:

The School District has adopted the following protocol for the use of the EpiPen/EpiPen Jr. This protocol will be followed for all students who have been identified by their physician as having an allergy with the potential for an anaphylactic reaction and for whom an EpiPen/EpiPen Jr has been prescribed.

1. A student who has been previously identified by his or her physician as having an allergy with the potential for an anaphylactic reaction, and who manifest signs of anaphylaxis, will be treated with EpiPen/EpiPen Jr. Administration is IM into anterolateral thigh.	
2. Student dose (check one):	<input type="checkbox"/> EpiPen Jr 0.15mg <input type="checkbox"/> EpiPen 0.30 mg
3. 911 will be called and the student will be transported to the nearest emergency department.	
4. A second dose of EpiPen/EpiPen Jr may be given, if available, if EMS has not arrived or symptoms of anaphylaxis have not abated after 15 minutes.	
5. Do you agree with the above treatment plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. If you answered no to #5, please make modifications to this protocol regarding the indications and mode of treatment. Please specify medication(s) ordered, the order of administration, and the disposition of the patient. Please use back of page if necessary.	
Note: If prescribing Benadryl please state whether it is to be given <i>before</i> or <i>after</i> EpiPen/EpiPen Jr:	

Date: _____	Prescriber's Signature: _____
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Printed Name: _____	Phone: _____
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The epinephrine administration plan for the Your School District is in conformity with Massachusetts Law: Section 1.105:210.100. We do our best to minimize student exposure to the common allergens. Our personnel are trained to administer Epinephrine in conformity with the recommendations of the Mass. DPH guidelines. The Anaphylaxis Protocols have been developed in accordance with current recommendations and guidelines published by the AAAAI, AAP and the AAF.

Please return this form to: (building, nurse's name, phone, fax)