

EMERGENCY MEDICATION PROCEDURE NESD HEAD START

Emergency medications necessary for a possible reaction to an allergy (bee sting, food) or for asthma will require a doctor's signature and a parent's signature on the "Allergy Action Plan" form.

The "Allergy Action Plan" form includes the following:

- 1) Student's name, date of birth, teacher and the allergy.
- 2) Step 1 Treatment: The physician will specify the appropriate medication to give according to the symptom listed on the form.
- 3) The physician will list the medication, dosage, and the route to give the medication to the child.
- 4) Step 2 Emergency Calls: Phone numbers will be listed on the form for the emergency contacts. Update phone numbers as they change.
- 5) The parent/guardian and the doctor's signatures and dates are required on the "Allergy Action Plan."
- 6) The back of the "Allergy Action Plan" has a place to list trained staff and graphic directions for using an Epi Pen.
- 7) The Head Start Health Coordinator or other trained professional will train the Head Start staff in the proper techniques for the administration, handling and storing of any emergency medication, and staff will sign and date that they have received training on the back of the "Allergy Action Plan".
- 8) These emergency medications will be stored where quickly accessible to staff (unlocked), but out of reach of children. The "Allergy Action Plan" will be with the medication and in the child's file at the center. A copy will be sent to the Health Services Coordinator.
- 9) A "Diet Prescription for Meals" form is not required when the "Allergy Action Plan" is required due to a food allergy.
- 10) When the Health Coordinator and the Health/Nutrition Manager are notified of a food allergy requiring an emergency medication, the appropriate signs will be made for the center (example: peanut/tree nut allergy).
- 11) In the event an emergency medication is given, documentation of the event will be made on an "Accident-Incident Report", with a follow-up contact in 24-48 hours.

Allergy Action Plan

Name: _____ D.O.B.: ____ / ____ / ____

Allergy to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

Place
Student's
Picture
Here

Extremely reactive to the following foods: _____

THEREFORE:

- If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
- If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough

HEART: Pale, blue, faint, weak pulse, dizzy, confused

THROAT: Tight, hoarse, trouble breathing/swallowing

MOUTH: Obstructive swelling (tongue and/or lips)

SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)

GUT: Vomiting, crampy pain



1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
 - Antihistamine
 - Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth

SKIN: A few hives around mouth/face, mild itch

GUT: Mild nausea/discomfort



1. GIVE ANTIHISTAMINE

2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Parent/Guardian Signature _____

Date _____

Physician/Healthcare Provider Signature _____

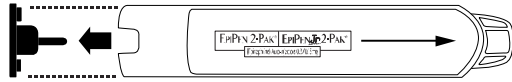
Date _____

TURN FORM OVER

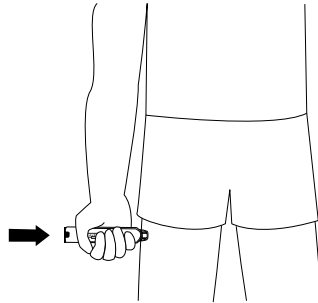
Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds



DEY® and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions



Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.



SECOND DOSE ADMINISTRATION: If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.



Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.



Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."



Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (____)_____-_____) Doctor: _____
 Parent/Guardian: _____

Phone: (____)_____-_____
 Phone: (____)_____-_____

Other Emergency Contacts

Name/Relationship: _____
 Name/Relationship: _____

Phone: (____)_____-_____
 Phone: (____)_____-_____