GROTON-DUNSTABLE REGIONAL SCHOOL DISTRICT

ANAPHYLAXIS TREATMENT PLAN AND PHYSICIAN'S ORDER FORM

Student Name: _____ **DOB:** _____

SECTION 1 - STUDENT ALLERGY HISTORY

1. Has this student had an anaphylactic reaction? ☐ No ☐ Yes, please state when and identify the offending agent: _____

2. Has this student ever been allergy tested? ☐ No ☐ Yes, date tested:_____

3. What is this student allergic to?

☐ Dairy	☐ Peanuts	☐ Soy	☐ Other:_____
☐ Eggs	☐ Sesame	☐ Tree Nuts	☐ Other:_____
☐ Fin Fish	☐ Shellfish	☐ Sting - Has venom testing been done? ☐ Yes ☐ No Has student been desensitized to the venom? ☐ Yes ☐ No	

4. Has an Epinephrine been prescribed for this student? ☐ Yes ☐ No

5. Has the student and family been educated about the avoidance of the offending agent? ☐ Yes ☐ No

6. Has the student and family been educated in the indications for Epinephrine administration, checking outdated medicine, and storing the Epinephrine? ☐ Yes ☐ No

7. Does student have a medical alert bracelet? ☐ Yes ☐ No

8. In your opinion, is this student able to safely self-administer the Epinephrine? ☐ Yes ☐ No

9. Does the student have asthma? ☐ Yes ☐ No

SECTION 2 - GROTON-DUNSTABLE SCHOOL DISTRICT EPINEPHRINE PROTOCOL

The Groton-Dunstable Regional School District has adopted the following protocol for the use of the Epinephrine. 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 Epinephrine 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):
   - ☐ Epinephrine 0.15mg
   - ☐ Epinephrine 0.30 mg

3. 911 will be called and the student will be transported to the nearest emergency department.

4. A second dose of Epinephrine may be given, if available, if EMS has not arrived and symptoms of anaphylaxis have not abated after 15 minutes.

5. Do you agree with the above treatment plan? ☐ Yes ☐ 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**.**

Date: _____ **Prescriber's Signature:** _____

Printed Name: _____ **Phone:** _____

The epinephrine administration plan for the Groton-Dunstable Regional 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 GDRSD Anaphylaxis Protocols have been developed in accordance with current recommendations and guidelines published by the AAAAI, AAP and the AAF.

I have read, understood and I am in agreement with the physician order for the treatment plan for anaphylaxis.

Date:_____ **Parent Signature:**_____

Please return this form to: School Nurse