# ALLERGY & ANAPHYLAXIS HEALTH CARE PLAN

# USE OF EMERGENCY MEDICATIONS TRAINING AND DELEGATION RECORD

|  |  |  |
| --- | --- | --- |
| School/Center |  | RN Instructor: Initials:Print |
| PROCEDURE GUIDELINE | RNInitials/ Date | RNInitials/Date | RNInitials/Date |
| 1. Confirms written authorization: Parent permission, Physician authorization, up to date Health Care Action Plan |  |  |  |
| 2. Verifies pharmacy labels for all prescribed medications. Checks expiration dates |  |  |  |
| 3. Verifies self carry contract |  |  |  |
| 1. Specific Care Training:
	* Describes difference between mild allergy and anaphylaxis symptoms
	* Identifies signs/symptoms indicating epinephrine use
	* Identifies signs/symptoms indicating antihistamine use
	* Identifies signs/symptoms indicating rescue inhaler use
	* States importance of monitoring for increased symptoms
	* Directs student to lie down and stay down
	* Confirms use of epinephrine ***first*** for potentially life threatening symptoms
	* Confirms importance of EMS activation
	* Indicates need/order for second dose of epinephrine
	* Identifies when to communicate with parent/guardian
 |  |  |  |
| 5. Describes documentation procedure |  |  |  |
| 6. Identifies process to communicate with RN |  |  |  |
| 7. Returns demonstration auto injector trainer and describes proper disposal |  |  |  |
| 8. Returns demonstration antihistamine administration |  |  |  |
| 9. Returns demonstration of rescue inhaler use |  |  |  |

I understand the need to confirm current health care action plan information for each student/child. I have had the opportunity to ask questions and received satisfactory answers.

|  |  |  |
| --- | --- | --- |
| **Delegatee Name (Print)** | **Delegatee Signature** | **Date** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Delegating RN Signature: Initials