St. Aloysius School
INSECT/FOOD ALLERGY MEDICAL - NURSING PROTOCOL

Please complete the following information, specific to your patient's needs.

Patient's Name: _____ Date of birth:_____

Patient's Address: _____
Telephone #: _____

Physician's Name:_____ Telephone #:_____

Diagnosis: _____
Specific Food/Insect Allergen: _____

If the patient is stung, or has ingested or he thinks he/she has ingested the above named food:
(Please number in order you wish protocol to occur.)
_____ Observe patient for symptoms of anaphylaxis**
_____ Administer EPINEPHRINE (via Epi-Pen) 0.30 cc before symptoms occur
_____ Administer EPINEPHRINE (via Epi-Pen) 0.30 cc if symptoms occur
_____ Administer BENADRYL _____
(state specific dose and routine)
_____ Transport to ER for observation if symptoms occur and contact above physician

_____ _____
Physician Signature Date

Parent/Guardian Authorization:
I hereby request that the above medication, ordered by the physician for my child _____ be administered by authorized school personnel.

Signature _____
Relationship to child _____
Address: _____Telephone #_____

**SYMPTOMS OF ANAPHYLAXIS

Chest tightness, cough, shortness of breath.
Swelling of lips, tongue, throat.
Hive or Hoarseness.
Dizziness or faintness.
Incontinence.
Coma.
Tightness in throat, difficulty swallowing.
Itching mouth.
Stomach cramps, vomiting, or diarrhea.
Excessive apprehension.
Excessive perspiration, cold clammy skin.