Allergy and Anaphylaxis Action Plan

TO BE FILLED OUT BY THE PARENT/GUARDIAN **AND** THE PHYSICIAN

Student: ________________________________ School: ____________________________ Birthdate: _____________________

Emergency Contact: ____ Phone: ____________________________

Treating Physician: ____ Phone: __________________ Fax: _________________

TO BE COMPLETED BY PARENT/GUARDIAN

Allergy to: _______________________________ Date of last reaction: _________________ Does student have asthma? □ Yes □ No

Has student ever experienced anaphylaxis? □ Yes □ No Was Epi-Pen used? □ Yes □ No

Please list the specific symptoms the student has experienced in the past? ____

Other allergies/health problems: ____

Routine medications (at home/at school): ____

How does student get to/from school: Bus □ Walk □ Car □

TO BE COMPLETED BY PHYSICIAN

Medicines/Doses

Epinephrine, intramuscular (list type) ___________________________________ Dose: □ 0.15mg □ 0.30 mg (weight more than 25 KG)

Antihistamine, by mouth (type and dose): ____

Other (for example, inhaler/bronchodilator if child has asthma): ____

Physician/HCP Authorization Signature: ____ Date: __________________________

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Provisions under 70 O.S. 1984, Section 1-1163, allow students to self-administer prescribed allergic medication. Approval to self-administer medications must be authorized by the prescribing physician. **The parent/guardian of the student it to provide the school an emergency supply of the student's medication.**

☐ I have instructed ______________________________ in the proper use of his/her medication and it is my professional opinion that this student is capable of self-administration of the medication and should be allowed to carry and use that medication by himself/herself.

Physician Signature: ____ Date: _________________________________

Action Plan

Mild Symptoms	What to do
• Itchy nose, sneezing, itchy mouth • A few hives • Mild stomach nausea or discomfort	Stay with child and: • Watch child closely • Give antihistamine (if prescribed) • Call parents • If symptoms of severe allergy/anaphylaxis develop, use epinephrine.
SEVERE Symptoms	**What to do**
• Shortness of breath, wheezing, or coughing • Skin color is pale or has a blush color • Weak pulse • Fainting or dizziness • Tight or hoarse throat • Trouble breathing or swallowing • Swelling of lips or tongue that bother breathing • Vomiting or diarrhea (if severe or combined with other symptoms) • Many fives or redness over body • Feeling of "doom", confusion, altered consciousness, or agitation	1. Inject epinephrine in thigh right away and note time when it was given. 2. Call 911 (before calling contact). 3. Stay with child and: a. Call emergency contact. b. Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side. 4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine. (Antihistamine, inhaler, etc.)

I give permission for school personnel to follow this plan, administer medication, care for my child, and contact my provider if necessary. I agree to release, indemnify and hold harmless Chandler Public Schools and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering medication to this student. I assume full responsibility for providing the school with prescribed medication. I understand this plan is valid for this school year only and must be renewed at the beginning of each school year.

Parent/Guardian: ____ Date: ______________________________