School District of Superior

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Allergy Action Plan

Picture

Student's Name:		**Date:**
School Attending:	**Grade:**	**Bus Student:** Yes No

Allergy to: _____**if exposed by being stung, ingesting, inhaling, skin contact.**
Asthmatic: yes* or no (*higher risk for severe reaction) **(circle above as indicated)**

Symptoms:		**Give Checked Medication**:** **(To be determined by physician authorizing treatment)	
• If a food allergen has been ingested, but no symptoms:		□Epinephrine	□Antihistamine
• Mouth:	Itching, tingling, or swelling of lips, tongue, mouth	□Epinephrine	□Antihistamine
• Skin:	Hives, itchy rash, swelling of the face or extremities	□Epinephrine	□Antihistamine
• Gut:	Nausea, abdominal cramps, vomiting, diarrhea	□Epinephrine	□Antihistamine
• Throat†:	Tightening of throat, hoarseness, hacking cough	□Epinephrine	□Antihistamine
• Lung†:	Shortness of breath, repetitive coughing, wheezing	□Epinephrine	□Antihistamine
• Heart†:	Thready pulse, low blood pressure, fainting, pale, blue	□Epinephrine	□Antihistamine
• Other†:	_____	□Epinephrine	□Antihistamine
• If reaction is progressing (several of the above areas affected), give:		□Epinephrine	□Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: Inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg Auvi-Q™ 0.3 mg Auvi-Q™ 0.15mg

Antihistamine: give: medication/dose/route _____

Other: give: medication/dose/route _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Possible Side Effects: _____

Direct contact shall be made with the physician should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state): _____

EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ at _____
3. Emergency contact: Name/Number/Relationship to student

_____/_____/_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Medication Consent: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed.
I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication.
I further agree to hold the School District of Superior, and the SDS employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school.
I agree to notify the school at the termination of this request or when any change in the above orders is necessary.

_____**Yes** _____**No** **Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.**

Parent's Signature:	**Date:**
Physician's Signature:	**Date:**