ALLERGIC REACTION EMERGENCY HEALTH CARE PLAN

ALLERGY TO: _____

Student's Name: _____ D.O.B. _____

Teacher: _____ Classroom: _____

Is child asthmatic? **Yes** _____ **(Higher risk of severe reaction!)** **No** _____

Signs of an Allergic Reaction Include (Circle student's usual symptoms):

MOUTH: itching and swelling of the lips, tongue or mouth

THROAT: itching and/or a sense of tightness in the throat, hoarseness and hacking cough

SKIN: hives, itchy rash and/or swelling about the face or extremities

GI TRACT: (uncommonly) nausea, abdominal cramps, vomiting and/or diarrhea

LUNGS: shortness of breath, repetitive coughing and/or wheezing

HEART: weak and "thready" pulse, "passing out"

The severity of symptoms can change quickly. All of the above symptoms can potentially progress to a life-threatening situation.

ACTION:

1. If ingestion, exposure or sting is suspected, give _____
(medication, dose, route)

and _____ immediately.
(other actions to be taken)

2. Call 911 or local Emergency Medical Services.

3. Call: Mother/Guardian:ph# _____ Father:ph# _____

Pgr/cell# _____ Pgr/cell # _____

Other emergency contacts _____

4. Or call Dr. _____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL EMS EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED.

_____ _____

Parent/Guardian Signature Date

_____ _____

Healthcare Provider's Signature Date

Staff members trained to give Epipen® as listed above (name and room #)
1.
2.
3.

Written Authorization for Self-Administration of EpiPen®, EpiPenJr.® or Twinject® Medication by Minor Children at School

Student Name: _____ Date of Birth: _____ Grade: _____

I, _____, Parent/Legal Guardian of the above-named student hereby request authorization for self-administration and possession of EpiPen®, EpiPenJr.® or Twinject® medication by this student while in school, at a school sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school operated property. The student demonstrates full understanding of the proper use of his/her asthma medication.

I understand that:

- the school district and its employees and agents shall incur no liability for: a) any injury to the student caused by his or her self-administration of medication except for injury caused by willful or wanton misconduct; b) the student's use, misuse, overuse, or neglected or failed use of his/ her allergy medication; and c) lost, misplaced, outdated, inaccessible, empty, or faulty allergy medication and allergy devices.
- the school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with allergy medication
- the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of allergy medication and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff.

I take sole responsibility for:

- the monitoring of allergy medication, medication use, and refilling of prescriptions for allergy medication as the school will not be responsible for the supervising, recording, and monitoring of self-administered allergy medication.
- ensuring the student always carries his/her allergy medication on his/her person.
- deciding if back-up medication will be kept at the school and providing the school with the back-up medication.
- informing school staff in writing of any changes in the student's treatment or allergy management.
- informing the school of any allergy exacerbations, hospital visits, and/or new or changed student medical information.
- informing school staff in writing of any medication side effects that warrant communication to the parent/guardian.
- coordinating distribution of the student's allergy management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus driver, before-school and after-school staff).

I understand and agree to the conditions of the school system policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above named student. I release the School System and its employees and agents of any legal responsibility related to the above named student's possession and self-administration of his/ her asthma medication.

_____ _____

Parent/Legal Guardian Signature Date

I, _____, the above-named student have been instructed in the proper use of my prescription allergy medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I understand and agree to the terms of the school policy.

_____ _____

Student's Signature Date

The above named student has been instructed and demonstrates understanding of the proper use of his/her allergy medication. It is my professional opinion that the student be permitted to carry and self-administer his/her allergy medication. I have provided the parent/guardian with a written alergy emergency/management plan including the name, purpose, dosage, and administration directions of the allergy medication.

_____ _____

Healthcare Provider Signature Date

Parent/Guardian Authorization to give Medication at School (for prolonged time period)

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed. Please write one medication per page.

Student's Name: _____

Teacher: _____ Grade: _____

I request that _____ School, through the principal or designee, supervise/assist in the administering of medication to my child, according to instructions the statements below. I understand that:

- Medications must be in the original labeled container (no baggies, foil, etc.). Pharmacists can provide a duplicate labeled container with only the school doses.
- Parent/guardian must provide specific instructions, as well as the medication and related equipment to the principal or clinic personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed and a newly labeled container is provided.
- All medication will be taken directly to the office/clinic by the parent.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

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Name of Medication: Epipen

Dose _____ Route (by mouth, topical, etc) _____

Time(s) to be given _____ Stop Medication on: _____

Physician's Name: _____ Physician's Phone: _____

I hereby authorize the personnel, employees and officials of the _____ School District to assist my child in taking prescribed medication according to district policy and I release them from any liability for administering this medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

_____

Parent/ Legal Guardian signature Date

Home Phone _____ Work Phone _____ Pager/Cell Phone _____

To be completed by your healthcare provider for prescription medications given for more than two weeks:

Condition/Illness Requiring Medication: _____

Possible Side Effects if any: _____

_____

Signature of Healthcare Provider Date

School Letterhead

Parent/Guardian Authorization to Give Medication at School

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed. Please write one medication per page.

Student's Name: _____

Teacher: _____ Grade: _____

I request that _____ School, through the principal or designee, supervise/assist in the administering of medication to my child, according to instructions the statements below. I understand that:

- Medications must be in the original labeled container (no baggies, foil, etc.). Pharmacists can provide a duplicate labeled container with only the school doses.
- Parent/guardian must provide specific instructions, as well as the medication and related equipment to the principal or clinic personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed and a newly labeled container is provided.
- All medication will be taken directly to the office/clinic by the parent.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

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Name of Medication: Benadryl

Dose _____ Route (by mouth, topical, etc) _____

Time(s) to be given _____ Stop Medication on: _____

Condition/Illness Requiring Medication: _____

Possible Side Effects, if any: _____

Physician's Name: _____ Physician's Phone: _____

I hereby authorize the personnel, employees and officials of the _____ School District to assist my child in taking prescribed medication according to district policy and I release them from any liability for administering this medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

_____

Parent/ Legal Guardian signature Date

Home Phone _____ Work Phone _____ Pager/Cell Phone _____

To be completed by School Health Clinic Personnel only:

Date received: _____ Name of Medication: _____ # Doses: _____