SUMNER COUNTY SCHOOLS

ALLERGY/ANAPHYLAXIS ACTION PLAN & MEDICATION ORDERS

Student's Name ____________________________________ DOB _______________ School ________________________

Grade/Teacher (homeroom) ____ Bus # _______________________

HISTORY OF ASTHMA? *YES or NO (*If yes student at higher risk for severe reaction)

BELOW TO BE COMPLETED BY PHYSICIAN / HEALTHCARE PROVIDER ONLY

ALLERGY (check appropriate):

- ☐ Foods (list): ____
- ☐ Stinging Insects (list): ____
- ☐ Other (explain): ____

RECOGNITION & TREATMENT- If food ingested or contact with allergen occurs observe for symptoms

(+) Potentially life-threatening symptoms **Give CHECKED MEDICATION**

Symptoms		**EpiPen**	**Antihistamine**
Mouth	**Itching, tingling, swelling of lips, tongue mouth**		
Skin	**Hives, itchy rash, swelling of the face or extremities**		
GI / Gut	**Nausea, abdominal cramps, vomiting, diarrhea**		
Throat +	**Tightening of throat, hoarseness, hacking cough**		
Lung +	**Shortness of breath, repetitive cough, wheezing**		
Heart +	**Thready pulse, low BP, fainting, pale, blueness in color**		
Neuro +	**Disorientation, dizziness, loss of consciousness**		
Other			
If reaction is progressing with several of the above areas affected (indicate action)			

DOSAGE

- ☐ **Antihistamine: Benedryl _____________ mg to be given *by mouth only if able to swallow*.**
- ☐ **Epinephrine (inject in outer, mid-thigh): ____**

STUDENT IS COMPETENT TO CARRY & SELF-ADMINISTER OWN EPI-PEN (circle)? YES or NO

EMERGENCY CALLS

1.) **CALL 911.** Call school nurse & SET Team.
2.) Call parent/guardian (notify of reaction, treatment, student's health status and continue to monitor until EMS arrives)

Physician Name (Print): ____ Phone: _________________________________

Physician Signature: ____ Date: __________________________

SIDE 2: TO BE COMPLETED by PARENT/GUARDIAN, STUDENT & SCHOOL

Student's Name: ____ DOB: ______________________

PARENT/GUARDIAN AUTHORIZATIONS (check all that apply)

- ☐ I want this allergy plan implemented for my child; **I want my child to carry their EpiPen** and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of EpiPen.
- ☐ I want this plan implemented for my child and I **do not** want my child to self-administer their EpiPen.
- ☐ I am aware the parent/guardian's responsibility is to provide a backup EpiPen in the event the student forgets or loses their EpiPen and/or antihistamine. The school district is not responsible or liable if backup medication is not provided to the school/school nurse and student is without working medication when medication is needed.

Your signature gives permission for the nurse to contact and receive additional information from your physician regarding the allergic condition(s) and the prescribed medication.

Parent/Guardian Signature **Phone** **Date**

STUDENT AGREEMENT:

- ☐ I agree to carry my EpiPen with me at all times;
- ☐ I have been trained in the use of my EpiPen and allergy medication and understand the signs & symptoms for which they are given;
- ☐ I will notify a responsible adult (teacher, nurse, coach, etc…) **IMMEDIATELY** when EpiPen is used;
- ☐ I will not share my medication with other students or leave my EpiPen unattended;
- ☐ I will not use my allergy medications for any other use than for what it is prescribed for.

Student Signature **Date**

- ☐ **Backup medication is stored at school (location)** ____
- ☐ **There is no backup medication at school (explanation)** ____

Trained Staff-Name	Title	Location	Trained By

Emergency Contact-Name	Phone #1	Phone #2

IN THE EVENT OF AN EMERGENCY, COMPLETE & GIVE A COPY TO EMS (Nurse should complete *Emergency Medication MAR*, as well)

Time Epinephrine was given: ____________________ **By whom?** ____

Time Benadryl (Diphenhydramine) was given: __________________ **By whom?** ____________________________

Time 911 called: ______________________ **By whom?** ____

School Nurse Signature **Date**