DUNCANVILLE INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES
ANAPHYLASIS MANAGEMENT AND TREATMENT PLAN

(This form must be renewed at the beginning of each school year)

ALLERGY/ALLERGIES TO: _____

Student's Name _____ Date of Birth _____Grade _____
(Last) (First)

Parent's Name _____ Daytime Phone _____

Physician's Name _____ Phone _____

Asthma □ Yes □ No

Systems	Possible Symptoms
Mouth	Itching and swelling of lips, tongue or mouth
Throat	Itching and/or sense of tightness in the throat, hoarseness, or hacking cough
Skin	Hives, itchy rash and/or swelling about the face or extremities
Abdomen	Nausea, cramps, vomiting and/or diarrhea
Lung	Shortness of breath, repetitive coughing, and/or wheezing
Heart	Thready pulse, passing out

The severity of symptoms can quickly change.
Symptoms can progress to life-threatening quickly.
Do not hesitate to call 9-1-1.

TO BE COMPLETED BY PHYSICIAN

The parent/guardian of the above named student has notified the school that he/she has a potentially life-threatening allergy and will require an Epinephrine Auto-Injector at school in the event of an emergency. Please complete this form based on your records and knowledge of this student and sign in the space provided.

ACTION PLAN FOR KNOWN OR SUSPECTED ANAPHYLAXIS REACTION

Action for Minor Reaction
Probable symptoms include:

_____
1. Administer

_____
(medication/dose/route)

2- Contact Parent/Guardian or emergency contact if parent/guardian unavailable

3. If condition does not improve in 10 minutes, follow steps for Major Reaction

Action for Major Reaction
Probable symptoms include:

_____
1. **IMMEDIATELY** administer

_____
(medication/dose/route)

2. Call 9-1-1 and tell them it is life-threatening
3. Contact Parents
4. Contact Physician _____
(phone number)

For Self Administration Only (Physician's initials required)

_____ This student has physician permission to self-administer his/her medication and carry the medication with him/her while at school and school related activities

_____ This student has been trained in the signs and symptoms of minor and major severe allergic/anaphylaxis reactions

_____ This student has been trained and is capable of self-administering an Epinephrine Auto-Injector safely in the school setting

Physician's Name:_____ Phone: _____

Address: _____

Physician's Signature: _____ Date: _____

TO BE COMPLETED BY PARENT

I request that an Epinephrine Auto-Injector be administered to my child, _____, as prescribed by his/her physician. I understand that the school administration will designate trained staff to perform this procedure in accordance with the physician's orders as given above. I will notify the school immediately if the health status of my child changes or there is any changes in his/her treatment. If the medication is administered while at school, I will provide the school with replacement medication the next school day. I give my consent for the release of all medical records pertaining to my child's severe allergy reactions/anaphylaxis and permission for appropriate school staff to contact the physician or health care provider for additional information if needed.

Parent's Signature:_____ Date: _____

FOR SELF ADMINISTRATION ONLY

I request that my child, _____ be allowed to self-administer his/her Epinephrine Auto-Injector. I understand that school administration will designate trained staff to monitor the procedure. It is my understanding that in performing this procedure my child will be expected to use a protocol that has been established and approved by his/her prescribing physician.

Parent's Signature: _____ Date: _____

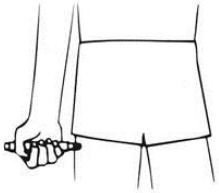
EMERGENCY CONTACTS:

1. _____ Relation _____ Daytime Phone: _____
2. _____ Relation _____ Daytime Phone: _____
3. _____ Relation _____ Daytime Phone: _____

FOR OFFICE USE ONLY

How to Use an Epinephrine Auto-Injector

1. Pull off gray safety cap
2. Place black tip on outer thigh (always apply to thigh)



3. Using a swing and jab motion, press hard into thigh until Auto-Injector mechanism functions. Hold in place and count to 10.
4. Remove and bend needle back on hard surface. Place back in plastic tube and send Epinephrine Auto-Injector/EpiPen® with patient to hospital.

STAFF TRAINED IN THIS PROCEDURE

1. _____
2. _____
3. _____