



Teacher: _____

Grade: _____

School: _____

FOOD ALLERGY AND ANAPHYLAXIS ACTION PLAN

NAME: _____ DOB: _____

ALLERGIES: _____ Asthmatic: Y / N

If they have these Symptoms:

Give this Medication: (circle)

1. If a food allergen has been ingested, but <i>no symptoms</i>	Epinephrine	Antihistamine
2. Mouth (Itching, tingling, or swelling of lips, tongue, mouth)	Epinephrine	Antihistamine
3. Skin (Hives, itchy rash, swelling of the face or extremities)	Epinephrine	Antihistamine
4. Gut (Nausea, abdominal cramps, vomiting, diarrhea)	Epinephrine	Antihistamine
5. Throat (Tightening of throat, hoarseness, hacking cough)	Epinephrine	Antihistamine
6. Lung (Shortness of breath, repetitive coughing, wheezing)	Epinephrine	Antihistamine
7. Heart (Thready pulse, low blood pressure, fainting, pale, blueness)	Epinephrine	Antihistamine
8. Other	Epinephrine	Antihistamine
9. If reaction is progressing (several of the above areas affected)	Epinephrine	Antihistamine

Medication Dosage:

Epinephrine auto injector: _____ Inject into outer thigh _____ 0.15mg OR 0.30mg

Antihistamine: _____
medication/dose/route/frequency

Other: _____
medication/dose/route/frequency

Give medication then CALL:

1. Call **911** (If epinephrine is given and/or symptoms are progressing to potentially life-threatening symptoms.)
2. Call School Nurse
3. Call Parent

The child named above is under my care. It is necessary for him or her to receive the above-prescribed medication during school hours. The medication may be administered by trained, nonmedical school employees, under the supervision of the school nurse. The school nurse may not be present during administration of the medication.

Physician: _____ Phone Number: _____

Physician's Signature/Clinic Stamp: _____ Date: _____

To be completed by parent/guardian:

I hereby give permission for school personnel to administer medication to my child during the school day as prescribed by the child's physician. Medications prescribed by my child's physician that are to be administered during school hours are listed on page one (the front of this form).

Signature of parent/guardian: _____ Date: _____

**PARENT AUTHORIZATION AND RELEASE FOR THE ADMINISTRATION
OF MEDICATION AT SCHOOL**

California Education Code Section 49423 allows the school nurse or other trained non-medical school personnel to assist students who are required to take medication during the school day, provided that appropriate authorization is given.

"Medication" includes prescription medication, over-the-counter medication, nutritional supplements and herbal remedies. Parents are responsible for providing all medication, supplies, and equipment necessary to administer the medication. No medications, including over-the-counter medications, will be given without a prescription. The medication prescription must be current and the medication must be supplied in the original package or original prescription bottle with the pharmacy label attached (ask your pharmacist to divide the medication into two bottles completely labeled: one for home and one for school). The medication must be prescribed to the student to whom it will be administered, and all medication containers must include a label with the student's name, physician's name, name of the medication, and the directions for use.

I authorize and hereby request that designated school personnel assist my child in taking this prescribed medication (including prescribed over-the-counter medication, nutritional supplements, and herbal remedies) as prescribed by my child's health care provider. I agree to, and do hereby release and hold the District and its employees and contractors harmless from any and all claims, demands, causes of action, liability or loss of any type, because of or arising from acts or omissions with respect to this medication and agree to indemnify each of them with regard to any judgment or claim rendered against them arising out of this medication administration arrangement. I understand that my child may not have or take medication at school unless all requirements are met. I hereby give consent for a school nurse to communicate with my child's health care provider and counsel school personnel as needed with regard to this medication.

_____ M F _____
Student's Name (Print) Sex Date of Birth

I have read and understood the above authorization and release. I will immediately notify the school if there is any change in medication my child is taking at school. I also understand that this authorization is in effect for a maximum of one school year, and the District will require a new authorization at the beginning of each school year, or if any changes in prescription occur.

_____ Date _____ Signature of Parent or Legal Guardian

Home Telephone: _____

Work Telephone: _____

Cell Telephone: _____