SEVERE ALLERGY EMERGENCY ACTION PLAN
LAKE LOCAL SCHOOL DISTRICT

Student's Name: _____ Date of Birth: _____

Grade: _____ Home Room Teacher: _____

Severe allergy to: _____

Is student Asthmatic? ❑ Yes ❑ No (If yes, student is higher risk for severe reaction)

Has EpiPen or Auvi-Q? ❑ Yes ❑ No If yes, where kept at school? _____

STEP 1: TREATMENT

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 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 BP, fainting, pale, blueness	❑ Epinephrine	❑ Antihistamine
• Other*	_____	❑ Epinephrine	❑ Antihistamine
• If reaction is progressing (several of the above areas affected), give		❑ Epinephrine	❑ Antihistamine

Are potentially life-threatening symptoms. The severity of symptoms can quickly change.

****ALWAYS CALL 911 IF EPINEPHRINE IS ADMINISTERED!****

DOSAGE

Epinephrine: inject intramuscularly *(circle one)* EpiPen EpiPen Jr. Auvi-Q 0.15mg Auvi-Q 0.3mg
(See reverse side for administration instructions)

Antihistamine: Give _____
Medication/Dose/Route

Other: Give _____
Medication/Dose/Route

STEP 2: EMERGENCY CALLS

1. Call 911. State that all allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Emergency contacts. See attached Emergency Medical Form.

***Even if Parent/Guardian cannot be reached, do not hesitate to medicate and/or call 911.*

Special instructions (to be completed by Physician):

_____ _____ _____
Physician's Signature (required) *Physician's Printed Name* *Date*

_____ _____
Physician's Address *Physician's Phone Number in case of emergency*

I authorize school personnel to implement this management and emergency plan as described above.

_____ _____ _____/_____/_____
Parent/Guardian Signature *Date* *Phone Numbers (Home/Work/Cell) in case of emergency*

THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR *Form AO_54 5/2020*

SELF-MEDICATION REQUEST FORM
(Epinephrine Autoinjectors)
LAKE LOCAL SCHOOL DISTRICT

Student Name _____ Building _____

School Year _____ Grade/Teacher _____ Date of Birth _____

Address _____

This portion to be completed by the physician or other prescribing health provider

Medication _____ Dosage _____ Time _____

Date administration of the medication is to begin: _____ end: _____

Adverse reactions that should be reported to the physician: _____

Procedure to follow in the event that the medication does not produce the expected relief from the student's anaphylactic reaction: _____

This student received instruction in the use of this injector by myself or my trained staff. It is my recommendation that this student carry his/her auto injector on his/her person at all times.

Yes No (circle one)

Physician/Authorized Prescribing Healthcare Provider Signature *Phone in case of emergency* *Date*

Printed Name *Address* *Telephone in case of emergency*

This portion to be completed by the Parent/Guardian

I request that my child be permitted to carry his/her epinephrine auto injector (Epipen) on his/her person while at school and for school related activities. I realize that my child will be required to have his/her injector on his/her person in order to go on any field trips or other extracurricular events off campus. **A back up injector is to be kept in the school clinic.** This form is valid for the remainder of this school year or until the prescribing doctor or other authorized healthcare provider discontinues this prescription/dose. I further understand that use of an Epipen will result in a 911 call and a call to the parents/guardians.

_____ _____ _____/_____/_____

Parent/Guardian Signature *Date* *Phone Numbers (Home/Work/Cell) in case of emergency*

File: JHCD-E
Attachment A

LAKE LOCAL SCHOOL DISTRICT

PRESCRIPTION Medication Request Form

Under provisions of the Ohio Revised Code, all public schools require the following information when children require administration of prescription drugs. Please complete the following information and return to the school.

Student Last Name	First	Middle
Student Address		

Building	School Year	Grade	Date of Birth

Name of Medication	Dosage/Administration Instructions
Administration of medication to BEGIN	Administration of medication to END
Significant side effect (adverse reactions) which should be reported to the physician:	
Special instructions for administration of the drug, include sterile conditions and storage:	

Physician's SIGNATURE	PRINT Physician's Name	Physician's EMERGENCY Phone Number

With full knowledge of any emergencies, dangers, and risks related to the administration of such medication by the Lake Local Schools employees, officers, or agents, we, the undersigned, hereby waive all claims which might arise from said administration of medication to said minor child. We hereby assume full responsibility for the administration of such medication to said minor child and the results thereof. We agree to indemnify and hold harmless Lake Local School District, Lake Local Board of Education, its members, offers, employees, and agents from any and all liability relative to the administration of such medication.

1. ***There must be <u>written</u> notification to the school if there is any change in the physician's medication order.***
2. ***Medication must be in the original container as dispensed by the physician or pharmacy.***
3. ***It is advised that the medication form and medication be brought to the school by the parent/guardian.***
4. ***The student must assume responsibility for presenting him or herself for the medication at the appropriate time.***
5. ***Parents hereby authorize school personnel to communicate with the pharmacist or physician to clarify order information and communicate student progress.***
6. ***It is the responsibility of the parent/guardian to retrieve any remaining medication at the end of the administration period (or school year). Any unclaimed medication will be disposed of prior to the next school year.***

_____ _____ _____/_____/_____

Parent/Guardian Signature | Date | Phone Numbers (Home/Work/Cell)