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Winnequah School (gr. EC, 4K-5) 800 Greenway Rd. Monona, WI. 53716 608-221-7677 fax: 608-223-6514		Taylor Prairie School (EC, 4K-1) 900 N Parkview St, Cottage Grove, WI 53527 608-839-8515 fax: 608-839-8323

## Monona Grove School District Life Threatening Allergy School Emergency Action Plan

Place  
Student's  
Picture  
Here

Student's  
Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade/Teacher \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Asthmatic? Yes\*  No  \*Higher risk for severe reaction

If Food allergic: (check one and sign below)  
This student should sit at a designated table/area in the cafeteria/classroom during lunch/snacks  
 Yes  No

### SIGNS OF AN ALLERGIC REACTION INCLUDE:

- MOUTH:** itching, tingling or swelling of the lips, tongue, or mouth  
**\*THROAT:** itching and/or a sense of tightness in the throat, hoarseness, or hacking cough  
**SKIN:** hives, itchy rash, and/or swelling of the face or extremities  
**GUT:** nausea, abdominal cramps, vomiting, and/or diarrhea  
**\*LUNG:** shortness of breath, repetitive coughing, and/or wheezing  
**\*HEART:** very fast "thready" pulse, and/or "passing out"

The severity of symptoms can quickly change! \*These symptoms are potentially life threatening

#### ACTION:

1.  If ingestion of \_\_\_\_\_ is suspected, or  If stung, or  if has above symptoms  
Give \_\_\_\_\_ and \_\_\_\_\_ immediately!  
*Medication/dose/route* *Medication/dose/route*

Medications are stored: \_\_\_\_\_

2. **CALL EMS (911)** - State that an allergic reaction has been treated and additional epinephrine may be needed.  
3. **CALL Mother:** \_\_\_\_\_ **CALL Father** \_\_\_\_\_  
**or emergency contacts: (1)** \_\_\_\_\_ **or (2)** \_\_\_\_\_  
4. **CALL Dr.** \_\_\_\_\_ **at** \_\_\_\_\_  
5. **DO NOT HESITATE TO ADMINISTER MEDICATION/CALL EMS EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!**

\_\_\_\_\_  
Doctor's signature (required)                      date                      Parent/Guardian signature (required)                      date

## Trained Staff Members

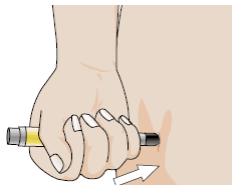
- |          |            |
|----------|------------|
| 1. _____ | Room _____ |
| 2. _____ | Room _____ |
| 3. _____ | Room _____ |

### EpiPen® and EpiPen® Jr. Directions

- Pull off **Blue** activation cap (pull straight off. Do not twist)



- Hold **Orange** tip near outer thigh (always apply to outer thigh)

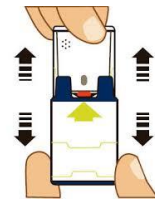


- Sit child down. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

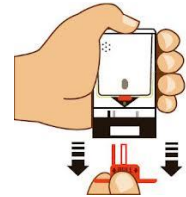
### Auvi-Q (Epinephrine) Directions



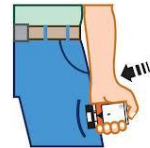
- Pull Auvi-Q from its outer case. Follow voice prompts.



- Sit child down. When ready to use, pull off RED safety guard.



- Place Black end against middle of OUTER thigh and press firmly (a click is heard). Hold in place for 5 seconds.



**Once EpiPen® or Auvi-Q® is used, call the Rescue Squad (911). Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.**

# EPI-PEN®/EPI-PEN JR.®/Auvi-Q® AUTHORIZATION/ RELEASE

Date \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_

Student's Name \_\_\_\_\_

## FOR COMPLETION BY PHYSICIAN

Physician's Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of Medicine: \_\_\_\_\_ Dose: \_\_\_\_\_

Is the child knowledgeable about his/her Epi-Pen® or Auvi-Q®?  Yes  No

Has the Child demonstrated the proper technique in administering the Epi-Pen®/Auvi-Q®?  Yes  No

Epi-Pen®/Auvi-Q® is administered when needed. Indications: \_\_\_\_\_

If needed, how soon can administration of Epi-Pen®/Auvi-Q® be repeated? \_\_\_\_\_

Side effects: \_\_\_\_\_

Comments: \_\_\_\_\_

### Please check all that apply:

I have instructed the above named student in the proper way to use his/her Epi-Pen®/Auvi-Q®. It is my professional opinion that he/she should be allowed to carry and use this medication by him/herself.

It is my professional opinion that the above named student should **not carry** and use his/her Epi-Pen®/Auvi-Q® by him/herself. If this box is checked, I authorize school staff to administer the medication named above and understand that the Epi-Pen®/Auvi-Q® will be kept in the school office and will be packed in a backpack to be taken on field trips.

\_\_\_\_\_  
**Physician's Signature**

\_\_\_\_\_  
**Fax Number**

\_\_\_\_\_  
**Phone Number**

## FOR COMPLETION BY PARENT

We, the parent/guardian of the above named student, request that assistance be provided to my child in taking the medicine(s) indicated above at school by authorized staff. If self-medicating is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by my physician and myself. **My child knows he/she must inform school personnel if he/she self-medicates.** Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

We, the parent/guardian of the above named student authorize permission for him/her to carry the medication on his/her person or keep same in his/her locker as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use of his/her Epi-Pen®/Auvi-Q®  Yes  No

**The school office has been provided with a back-up Epi-Pen®/Auvi-Q®:**  Yes  No

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Oct. 2013 LH form available at [www.mononagrove.org](http://www.mononagrove.org)