ALLERGY TREATMENT PLAN

School District of Wisconsin Dells, Wisconsin Dells, WI **EFFECTIVE DATE:**_____**to**_____

Student: _____ **DOB:**_____ **School:**_____

Address: _____ **Grade:**_____

Name of Physician or Advanced Practice Provider (APP): _____ **Phone#**_____

Clinic:_____ **Address:**_____

ALLERGY TO:_____

Epinephrine Auto Injector Medication: Intermuscular (IM) Injection

Dose: ____ Adult 0.3mg
____ Junior 0.15mg

Brand: ____ EpiPen
____ Auvi-Q
____ Adrenaclick
____ Other: _____

Student Photo

Oral Antihistamine: Benadryl (Diphenhydramine) _____mg **INSTRUCTIONS:** _____

Other (Name and Dose): _____ **INSTRUCTIONS:** _____

Treat as indicated below:

Exposed, but no symptoms	❑ Oral Antihistamine	❑ Epinephrine/Call 911
Mouth: Itching, Tingling	❑ Oral Antihistamine	❑ Epinephrine/Call 911
Skin: Hives, itchy rash, swelling (no facial or mouth swelling)	❑ Oral Antihistamine	❑ Epinephrine/Call 911
Swelling: Lips, tongue, mouth or face	❑ Oral Antihistamine	❑ Epinephrine/Call 911
GI: Abdominal cramping, nausea, vomiting, diarrhea	❑ Oral Antihistamine	❑ Epinephrine/Call 911
*Throat: Tightness of throat, hoarseness, hacking cough	❑ Oral Antihistamine	❑ Epinephrine/Call 911
*Breathing: Shortness of breath, continuous coughing, wheezing	❑ Oral Antihistamine	❑ Epinephrine/Call 911
*Cardiac: Pale skin, blue lips/mouth, weak or thready pulse, low BP, fainting	❑ Oral Antihistamine	❑ Epinephrine/Call 911

***Life-threatening; Severity of symptoms can change quickly. CALL 911**

Any additional instructions: _____

PARENT/GUARDIAN CONSENT:

- I request and authorize that this medication/procedure be administered at school by non-medically trained school personnel.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication/procedure at school.
- I agree that a parent/guardian/responsible adult will deliver the medication to the school office in its original, properly labeled container.
- I will obtain a new Physician's order and notify the school in writing if there are any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's Physician regarding this medication and allergy plan.
- AUTO-INJECTING EPINEPHRINE: This student is capable of self-administration and may carry and self-administer in school. **Yes** ____ **No** ____
- HIGH SCHOOL STUDENTS ONLY: This student is capable of self-administration and may carry and self-administer the above over-the-counter antihistamine in school. **Yes** _____ **No** _____
- My signature indicates that I have fully read and understand the above information.

_____ _____ _____

Signature of Parent/Legal Guardian **Date** **Phone#**

PHYSICIAN ORDER:

The above medication/procedure is to be administered/performed in accordance with the above instructions and agreements. I agree to exchange information verbally or in writing with school personnel regarding the above medications and allergy plan. I understand the above medication will be given by non-medically trained school personnel. **AUTO-INJECTING EPINEPHRINE:** This student and parents/guardians have been instructed in self-administration and the student may carry and self-administer in school. **Yes** _____ **No** _____

_____ _____

Physician Signature **Date**