

Edina Kids Club/WISE Guys - Severe Allergy Action Plan Please have physician complete and sign this two-page form.

| Student's Name: | Date of Birth: | |
|--|---|--|
| School: | Grade: | |
| Severe Allergy to: | | |
| _ | on/history of anaphylactic reaction? Yes No pital visits for allergic reaction: | |
| What specifically would trigger an allergic reaction? (i.e. ingesting, touching, proximity to a particular allergen, etc. | ?) | |
| What is the best way to avoid an allergic reaction? (i.e. no foods containing the allergen, must sit at an allergen-from the allergen, etc.) | ee table for meals, cannot be in the same room with | |
| Step 1: Treatment | | |
| Symptoms: | Give Checked Medication: (To be determined by physician authorizing treatment) | |
| Mouth: Itching, tingling, swelling of the lips, tongue or mou Skin: Hives, itchy rash, swelling of face or extremities Gut: Nausea, abdominal cramps, vomiting, diarrhea Throat:* Tightness of throat, hoarseness, hacking cough Lung:* Shortness of breath, repetitive coughing, wheezing Heart:* Thready pulse, low blood pressure, fainting, pale, bl » If a food allergen has been ingested, but no symptoms: » If exposure to allergen other than by ingestion (skin/in If reaction is progressing (several of the above areas affecte The severity of symptoms can quickly change. *All above symptoms can pot Medication and Dosage: Epinephrine: inject intramuscularly (circle one): EpiPen® 0.3mg E Antihistamine: give | th | |
| Other: give | <u>'</u> | |
| Medication/Dose/Route | Repeat when? | |
| Physician Signature (required): | Date: | |
| Print Physician/Clinic Name: | Phone: | |
| Additional Information (if needed): | | |

| Step 2: Emergency Calls (to be made by program staff) | | | | | | | | |
|---|---|--------------------|-----------|----------------|-------------------|------------|--|--|
| 1. | 1. Call 911 immediately. 911 MUST BE CALLED if EpiPen [®] is administered. State that an allergic reaction has been treated and additional epinephrine may be needed. | | | | | | | |
| 2. | 2. Dr at | | | Transport to: | | lospital | | |
| 3. | Emergency Con | tacts: | | | | | | |
| Pa | Parent/Other Emergency Phone Number(s) | | | | | | | |
| 1. | 1 a) | | a) | b) b) b) | | | | |
| 2. 3. | | | a) a) | | b) b) | | | |
| EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR HAVE CHILD TRANSPORTED TO EMERGENCY MEDICAL FACILITY! | | | | | | | | |
| | PHYSICIAN/LICENSED PRESCRIBER'S ORDER FOR ADMINISTRATION OF MEDICATION BY COMMUNITY ED STAFF To be completed by physician/licensed prescriber | | | | | | | |
| М | edication | Dose in mg | Frequency | Route | Medical Condition | Other Info | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| Print Name of Physician/Licensed Prescriber | | | | | Clinic Name | | | |
| Phone | | | Fax | | | | | |
| Signature of Physician/Licensed Prescriber (required) | | | |) | Date | | | |
| Parent/Guardian Authorization 1. I request that the above medication/s be given at Kids Club/WISE Guys as ordered by my child's physician/licensed prescriber. 2. I give permission for my child to carry the above medication in their backpack. Yes No Comments: 3. I request that the above medication be send on field trips. Yes No Comments: 4. I will notify Kids Club/WISE Guys if medication is stopped or changed. 5. I give permission for the medication/s to be administered by Kids Club/WISE Guys personnel (not a licensed nurse.) 6. Legally I may refuse to sign the Severe Allergy Action Plan. If I refuse to sign, Kids Club/WISE Guys will not be able to administer the prescribed medication. 7. This consent may be revoked at any time by sending a written notice to Kids Club/WISE Guys. | | | | | | | | |
| Parent/Guardian Signature Date | | | | | | | | |
| Pe | ermission for Relea | ase of Information | | | | | | |
| 1. | I give permission for the Kids Club/WISE Guys staff to communicate, as needed, with school staff about my child's medical condition/ and the action of the medication/s. | | | | | | | |
| 2. | I give permission for the Kids Club/WISE Guys staff to contact my child's physician/licensed prescriber regarding questions about the above listed medication/s or medical condition/s being treated by medication/s. | | | | | | | |
| Parent/Guardian Signature Date | | | Date | | | | | |