BERMUDIAN SPRINGS SCHOOL DISTRICT

ANAPHYLAXIS (SEVERE ALLERGIC REACTION) MANAGEMENT PLAN

Student's name: _________________________ School year: _________Grade/Teacher: _________________

You have indicated on the Emergency Card that your child has an allergic reaction to an item. In order for school personnel to respond to this quickly and effectively, additional information is necessary. This information will be shared with those individuals that have a need to know.

My child's anaphylaxis (severe allergic reaction) triggers are:

□ Peanuts □ Tree nuts □ Insect stings
□ Milk □ All dairy products □ Wheat
□ Fish □ Shellfish □ Medications (please specify):_____________________________
□ Eggs □ Latex □ Food additives (please specify): ____________________________
□ Other (please specify): ____

My child's anaphylaxis symptoms are usually:

□ Swelling (eyes, lips, face, tongue) □ Coughing or choking □ Hives
□ Flushed face or body □ Cold, clammy, sweaty skin
□ Difficulty breathing or swallowing □ Stomach cramps, diarrhea, vomiting
□ Dizziness, confusion, fainting, or loss of consciousness
□ Other (please specify): ____
□ Unknown

My child requires the following medication if a reaction occurs:

□ Benadryl
□ Epinephrine Auto-Injectors (The "Physician Section" on the reverse side **must** be completed by your family physician)
□ Other (May require completion of "Physician Section" on reverse side): _______________________________
□ My child requires the following procedures or precautions to help prevent a reaction at school:
____

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication or its administration when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken or self-administered properly. I am aware that any improper use/sharing of the above named medication by the student to whom it is prescribed or failure to comply with the District's policy will result in the immediate confiscation of the medication, loss of privilege to self-administer, and possible disciplinary consequences.

- My child may self-administer the above medication as prescribed by his/her physician. (**All areas in the "Physician Section"[on reverse side] must be completed for the student to be able to self-administer the medication).**
- My child will report to the school nurse or designated personnel immediately following each use of the medication. The nurse may assess and monitor student use to assure that safe practices are being followed.
- I understand that this authorization must be renewed on an annual basis.

_________________________________ _________________
Parent/Guardian Signature Date

Student Section
I agree to be solely responsible for my medication and to follow the directions for its use as ordered by my physician and the school nurse, as well as the district's medication policy. I agree to notify and report to the school nurse immediately following each use of any medication. I agree that my medication is for my use only and may not be shared with others. I am aware that any abuse of the privilege will result in the confiscation of my medication and/or other disciplinary consequences.

Student's Signature____ Date__________________

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Epinephrine Injections:
□ 0.15mg Epinephrine Auto-Injectors □0.3mg Epinephrine Auto-Injectors

Please check all that applies:
- □ Student is knowledgeable about this medication, how to administer it, and understands that he/she may not share the medication with another person.
- □ Student is qualified to self-administer this medication as prescribed by his/her physician and may carry it with them while on school property and school-sponsored events or activities.

Additional Medications for Anaphylactic Reactions (ex: Prednisone)

Medication #1
Medication Name ________________________________ Dosage_______________

Route _____________________________ Side Effects ____

Indications of when to administer the above medication: ____

Medication #2
Medication Name ________________________________ Dosage_______________

Route _____________________________ Side Effects ____

Indications of when to administer the above medication: ____

Comments:
Any additional information needed to treat this student at school should he/she have an anaphylactic reaction.
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____

The child requires the following procedures or precautions to help prevent a reaction at school:
____
____

Physician's Name ____ Phone ____________
(Please Print)
Address: ____

Physician's Signature ____ Date _____________

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