Allergy Action Plan

Monticello Public Schools Health Services

Physician: Please complete this page **Parent/Guardian: Please complete page 2**

Student _____ Date of Birth_____ Grade_____
School _____ Teacher_____

Physician: _____ Clinic: _____
Phone: _____ Fax: _____

ALLERGY TO: □Peanuts □Nuts (Specify)_____ □Eggs □Seafood (Specify) _____
□Latex □ Insect Bites (Specify)_____ □ Other (Specify)_____

History of Asthma: □ Yes* □ No History of Anaphylaxis: □ Yes* □ No *More at risk for severe reaction
Date of last reaction: _____ Explain what happened: _____

MEDICATIONS

EPINEPHRINE:
□ Epinephrine _____

ANTIHISTAMINE:
□ Benadryl (also known as Diphenhydramine)
□ Other antihistamine _____

Epinephrine located: ☐ Health Services ☐ Self carry ☐ Backpack ☐ Other _____
Student has been instructed how to use their epinephrine: ☐ Yes ☐ No
If able, student will give themselves epinephrine: ☐ Yes ☐ No
☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion: **One or more** of the following: LUNG: Short of breath, wheeze, repetitive cough HEART: Pale, blue, faint, weak pulse, dizzy, confused THROAT: Tight, hoarse, trouble breathing/swallowing MOUTH: Obstructive swelling (tongue and/or lips) SKIN: Many hives over body Or **combination** of symptoms from different body areas: SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips) GUT: Vomiting, crampy pain	→	1. **INJECT EPINEPHRINE IMMEDIATELY** 2. Call 911 3. Begin monitoring (see box below) 4. Give additional medications.* - Antihistamine - Inhaler (bronchodilator) if asthma *Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.
MILD SYMPTOMS ONLY: MOUTH: Itchy mouth SKIN: A few hives around mouth/face, mild itch GUT: Mild nausea/discomfort	→	1. **GIVE ANTIHISTAMINE** 2. Call parent and LSN 3. If symptoms progress (see above), USE EPINEPHRINE

Monitoring

Stay with student; call parent and LSN. Tell 911 that epinephrine was given. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised.

Physician Authorization

I authorize the above plan to be followed in school.

Physician's Signature: _____ Printed Name of Physician: _____ Date: _____

Allergy Action Plan

Monticello Public Schools Health Services

Parent/Guardian: Please complete this page

Student _____ Date of Birth_____ School _____ Grade_____
Parent/Guardian _____ H#_____ W# _____ C# _____
Parent/Guardian _____ H#_____ W# _____ C# _____

FIELD TRIPS: · Send prescribed medications and Action Plan. · 911 will be called, as needed.

EPINEPHRINE CONTRACT BETWEEN STUDENT, PARENT, AND HEALTH SERVICES PERSONNEL

Qualified students will be allowed to carry their own epinephrine. This is dependent on an assessment of the child's knowledge and skills to safely possess and use an epinephrine.

FOR SCHOOL HEALTH SERVICES PERSONNEL USE ONLY

For permission to carry epinephrine:

- Student has demonstrated to Health Services personnel correct use of epinephrine.
- Student agrees never to share the epinephrine with another person.
- Student agrees he/she will go to Health Services immediately after use of epinephrine.

Student Signature:
_____ Date: _____

School Health Personnel Signature:
_____ Date: _____

I give permission for my child, _____ to carry their epinephrine. I understand that they must follow the rules listed above. I will notify the school of changes in medication or my child's condition. **Please note: It is recommended to have a back-up epinephrine that is kept in Health Services.**

Parent/Guardian Signature: _____ Date: _____

PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Health Services of any change in the medication(s) (i.e. dosage change, medication is discontinued, etc.).
4. I give permission for Health Services personnel to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).
5. I give permission for the medication(s) to be given by the designated personnel as delegated by the licensed school nurse.
6. If your child has any remaining medication(s) in Health Services during or at the end of the school year, we would prefer to have you pick it up. If you are unable to pick up the medication(s) and would like us to send the medication(s) home with your child, your written permission is required. Please indicate below which plan we are to follow. If you have any questions or concerns call Health Services at your child's school.

□ **Plan A (preferred):** I will pick up my child's medication at school.
□ **Plan B:** Please send the medication with my child.

NOTE: Medication must be supplied in original/prescription bottle.

Parent/Guardian Signature: _____ Relationship to Student: _____ Date: _____

PARENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for Health Services Personnel to communicate as needed, with school staff about my child's medical condition(s).
2. I give permission for the physician to release information about my child's medical condition(s) to Health Services and school staff, as needed.

This authorization may be revoked by you at anytime in writing and expires in one calendar year.

Parent/Guardian Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION FOR ACTION PLAN

Bus cards are no longer being mailed out. ISD 728 will inform the bus company that your child has a medical action plan on file with the Health Office. Please notify the bus company directly of any specific directions for your child's care while riding the bus.

I authorize the above plan to be followed in school.

Parent/Guardian Signature: _____ Date: _____

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