

**COUNCIL ROCK SCHOOL DISTRICT  
ANAPHYLAXIS EMERGENCY ACTION PLAN**

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Allergy To:** \_\_\_\_\_

**Asthmatic:** \_\_\_\_ Yes \_\_\_\_ No

◆ **STEP 1: TREATMENT** ◆

**SYMPTOMS** (The severity of symptoms can quickly change. \*Potentially life-threatening.) **Give Circled**

**Medication\***

Mouth	Itching, tingling or swelling of lips, tongue, mouth	Epinephrine	Antihistamine
Throat*	Itching, tightness of throat, hoarseness, hacking cough	Epinephrine	Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	Epinephrine	Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine
Lung*	Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
Heart*	"Thready" pulse, low BP, fainting, pale, blueness	Epinephrine	Antihistamine
Other	_____	Epinephrine	Antihistamine

**Medications**

Epinephrine: \_\_\_\_\_ 0.3MG \_\_\_\_\_ 0.15MG INJECTED INTO OUTER THIGH

Antihistamine: \_\_\_\_\_

**YES**  **NO** **Both the medical provider and the parent feel that the child may carry their emergency medication**

**YES**  **NO** **Both the medical provider and parent feel that the child may carry and self-administer their emergency medication**

**Student must verbalize/demonstrate understanding of self carry and/or self-administration of medications to school nurse.**

**Health Care Provider Printed Name:** \_\_\_\_\_

**Health Care Provider Signature:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

◆ **STEP 2: EMERGENCY CALLS** ◆

1. Call 911 State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Emergency contacts:

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

**Parent/Guardian Consent**

I give my permission for my child to receive the following medication ordered by a licensed prescriber during the school day and release the Council Rock School District and its employees from liability for any damages my child may suffer because of this request. I understand that the medications will be given as directed according to my child's licensed prescriber's directions. Your signature gives permission for the nurse to contact and receive additional information from your health care provider regarding their medical condition(s) and the prescribed medication.

**YES**  **NO** **My child requires special seating in the cafeteria**

**Parent Signature:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

## COUNCIL ROCK SCHOOL DISTRICT

### MEDICATION/TREATMENT GUIDELINES

- The Medication/Treatment Dispensing Form on the reverse side must be completed by both the prescribing licensed provider (physician, dentist) and the parent/guardian for all FDA approved medication (prescription and over the counter) that must be administered during the school day. No medication will be administered without the proper completion of the Medication/Treatment dispensing form.
- Administration of all medications will be given in accordance with Council Rock School District's Medication Policy and in accordance with the Pennsylvania Department of Health guidelines for Pennsylvania schools for the administration of medications and emergency care.
- Medication will be administered to a student during school hours only when such medication is needed by the student to remain in school and administration is required during school hours. If possible, prescribing licensed providers should time administration of medication to be given at home, before or after school.
- Prescription medication as well as non-prescription medications must be delivered to the school nurse in the original labeled pharmacy container or box by a parent/guardian.
- Failure to provide documentation will require the parent/guardian to be present in school to administer the medication personally.
- Under no circumstances will the first dose of any medication be given at school due to the risk of an adverse reaction.
- Acetaminophen or Ibuprofen, for which the district has a standing order from the district physician, will be administered as needed to all students with the signed permission of a parent or guardian as noted on the student's emergency information form.
- In accordance with Act 187 of the school code and CRSD procedures, students requiring rescue inhalers, Epi-pens, Diabetic medications/supplies may be permitted to self-carry and/or self-administer medications with a completed permission form. In addition to the completion of the permission form, self-administration also requires a competency assessment by the school nurse.

#### Student Agreement:

- I have been trained in the use of my emergency medication;
- I agree to carry my emergency medication with me at all times
- I will notify a responsible adult immediately if EpiPen is used to call 911
- I will not share my medication with other students or leave it unattended
- I will not use my medications for any other use than what it is prescribed for

Student Signature \_\_\_\_\_ Date: \_\_\_\_\_