



Name _____ DOB _____

Allergies NKDA Yes _____

Asthma Yes (high risk for severe reaction) No

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CANNOT BE DEPENDED ON DURING AN ANAPHYLACTIC EPISODE.

Health problems in addition to anaphylaxis Yes _____ No

Daily medications Yes _____ No

Symptoms of Anaphylaxis

MOUTH	itching, swelling of lips and/or tongue
THROAT	itching, tightness/closure, hoarseness
SKIN	itching, hives, redness, swelling
GUT	vomiting, diarrhea, cramps
LUNG	shortness of breath, cough, wheeze
HEART*	weak pulse, dizziness, passing out

*Only a few symptoms may be present. Severity of symptoms can change quickly.
Some symptoms can be life-threatening. ACT FAST!

Emergency Actions Steps – DO NOT HESITATE TO GIVE EPINEPHRINE!

- Inject epinephrine in thigh using (check one)
 - Adrenaclick (0.15 mg) Adrenaclick (0.3 mg) Auvi-Q (0.15 mg) Auvi-Q (0.3 mg)
 - EpiPen Jr (0.15 mg) EpiPen (0.3 mg)

Epinephrine Injection, USP Auto-injector-authorized generic

- (0.15 mg) (0.3 mg)
- Other (0.15 mg) Other (0.3 mg) Specify other _____

2. Call 911

- Emergency contact #1 Name _____ cell# _____ work# _____
 Emergency contact #1 Name _____ cell# _____ work# _____
 Emergency contact #1 Name _____ cell# _____ work# _____

SELF ADMINISTERED EMERGENCY MEDICATION

- I have instructed student in the proper way to use his/her emergency medication. It is my professional opinion that this student **SHOULD** be allowed to carry and self-administer his/her emergency medication. **Physician's Initial** _____
- It is my professional opinion that this student **SHOULD NOT** carry or self-administer his/her emergency medication. **Physician's Initial** _____

Health Care Provider Name _____ Signature _____ Date _____

Address _____ Phone# _____



To Be Completed by Parent/Guardian, student, and MISD Health Clinic staff

Parent/Guardian AUTHORIZATIONS

- I want this allergy plan implemented for my child. **I want my child to carry the EpiPen.** I agree to release MISD school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of Epi-Pen.
- I want this plan implemented for my child. **I do not** want my child to self-administer EpiPen.

It is recommended that backup medication be stored with the campus clinic in case a student forgets or loses EpiPen and/or antihistamine.

MISD is not responsible or liable if backup medication is not provided to the campus clinic.

MISD is not responsible if the student is without his/her medication (if order is for student to carry and self-administer his/her emergency medication).

Parent/Guardian Name _____ Signature _____ Date _____

Phone # _____ Alternate Phone # _____

Student Agreement

- ▶ I have been trained in the use of my EpiPen and allergy medication and understand the signs and symptoms for which they are given.
- ▶ I agree to carry my EpiPen with me at all times.
- ▶ I will notify staff (teacher, nurse, coach, etc.) **IMMEDIATELY** if/when auto-injector EpiPen (epinephrine) is used.
- ▶ I will not share my medication with other students or leave my EpiPen unattended.
- ▶ I will not use my allergy medication for any other use than what it is prescribed for.

Student signature _____ Date _____

Back up medication is stored at school Yes No

Nurse/Clinic Assistant Name _____ Signature _____ Date _____