# ALLERGY/ANAPHYLAXIS EMERGENCY PLAN & MEDICATION AUTHORIZATION

**Student:** _____ **DOB:**_____ **School Year 2024-2025**

**Grade:**_____ **School:** WDHS_____ WDMS_____ SHE_____ LDE_____

**Healthcare Provider:**_____ **Clinic:**_____ **Phone:**_____

**Parent/Guardian:**_____ **Phone:**_____ **Alt:**_____

**ALLERGIC TO:** _____ **History of Asthma:** ⬜ YES ⬜ NO

| | SEVERE SYMPTOMS |
|---|---|
| LUNG | Short of Breath, wheezing, repetitive cough |
| HEART | Pale, blue, faint, weak pulse, dizzy |
| THROAT | Tight, hoarse, trouble breathing/swallowing |
| MOUTH | Significant swelling of the tongue and/or lips |
| SKIN | Many hives over body, widespread redness |
| GUT | Repetitive vomiting or severe diarrhea |
| OTHER | Feeling something bad is about to happen, anxiety, confusion *OR a combination of mild or severe symptoms from different body areas. |

## EMERGENCY PROCEDURE

1. **INJECT EPINEPHRINE IMMEDIATELY for ANY of the listed SEVERE symptoms** (Note time given)
2. **CALL 911.** Tell the emergency dispatcher that epinephrine was given.
3. Give antihistamine, if ordered below.
4. Given rescue inhaler, if ordered below.
5. Lay the student flat and raise legs, keep warm. If student has difficulty breathing or is vomiting, let them sit up or lie on their side.
6. After 5 minutes, if symptoms do not improve or worsen, give second dose of epinephrine..
7. Alert emergency contacts (parent/guardian).
8. If stung by insect, apply ice to the site.

| | MILD SYMPTOMS |
|---|---|
| NOSE | Itchy/runny nose, sneezing |
| MOUTH | Itchy mouth |
| SKIN | A few hives, mild itch |
| GUT | Mild nausea/discomfort |

## PROCEDURE

1. **GIVE ANTIHISTAMINES, IF ORDERED BELOW.**
2. Stay with student & watch closely for changes.
3. Alert emergency contacts. (parent/guardian)
4. If stung by insect, apply ice to the site.
5. If symptoms worsen or involve more than one body system area **GIVE EPINEPHRINE and CALL 911.**

## EMERGENCY MEDICATIONS:

**EPINEPHRINE**

⬜ **Epinephrine** (0.15mg) inject intramuscularly (circle one) EpiPen Auvi Q Adrenaclick

⬜ **Epinephrine** (0.3mg) inject intramuscularly (circle one) EpiPen Auvi Q Adrenaclick

**A second dose of epinephrine can be given 5 minutes or more after the first dose if symptoms persist or recur**

**ANTIHISTAMINE**
Do not depend on antihistamines or inhalers. When in doubt, give epinephrine & CALL 911.

⬜ **Benadryl/Diphenhydramine**
**Dose:**_____**mg**
**Route: Oral**

⬜ **Other**
**Dose:**_____**mg**
**Route:**

**PARENT/GUARDIAN CONSENT:** (Review each item before signing)

- I understand that all medication is to be delivered to the school and picked up from the school by parent/guardian/ responsible adult unless the healthcare provider below indicates that student may self carry, self-administer medication.
- I will supply medication in it's original, dated, properly labeled container. (request extra bottle from the pharmacy)
- I understand that this order is in effect for the current school year only, unless otherwise indicated.
- I request and authorize that school personnel administer this medication or perform this procedure at school.
- I will obtain a new Physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's healthcare provider regarding this medication/procedure or the conditions for which it is prescribed.
- I understand that non-medical, trained school personnel will be administering medications & performing procedures.
- I understand that I am responsible to assure that backup rescue medication is available to my child outside of school hours and traveling to/from and during school-sponsored events.
- I agree to hold the School District of Wisconsin Dells, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication/procedure at school.
- **For any age student: ASTHMA INHALERS & EPIPENS ONLY**
- This student is capable of self-administration & may carry an inhaler or EPIPEN & self-administer in school. ( ) YES ( ) NO
- My signature indicates that I have fully read and understand the above information.

_____ _____ _____
**Signature of Parent/Legal Guardian** **Date** **Phone Number**

**PHYSICIAN ORDER:**

**The above medication/procedure is to be administered during the school day in accordance with the above instructions and agreements. I agree to exchange information verbally or in writing about the student/medication/procedure and understand that non-medical, trained school personnel will administer the medication/procedure.**

**SELF CARRY, SELF ADMINISTER: For any age student: ASTHMA INHALERS & EPIPENS ONLY This student and their parents/guardians have been instructed in self-administration and student may carry an inhaler or EPIPEN & self-administer in school. ( ) YES ( ) NO**

_____ _____ _____
**Signature of Licensed Healthcare Provider** **Date** **Phone Number**

_____ _____
**Printed Name** **Fax Number**