# Canon McMillan School District
# Parental Release of Allergy Information

Your child has been identified with an allergy that could have serious implications on his/her health. For your child's safety, the allergy information contained in his/her Individualized Medical Plan (IMP) and/or their Allergy Action Plan will be shared with all school employees having contact with him/her. This will include classroom teachers, Related Arts teachers, nurses, paraeducators, custodians, bus drivers, substitute employees, and any other Canon McMillan employee that will have contact with your child. This information will be shared on a "need to know" basis and will be kept confidential by these employees.

Our goal is to provide a safe and healthy environment for every child. Sharing this information with appropriate personnel will provide important communication between home and school to help achieve this goal.

Please complete this form and return it to your child's school nurse or principal.

Student's Name _____ Grade _____

Allergy to: _____

_____ Yes, I give permission for my child's allergy information to be shared with the appropriate school personnel as outlined above.

Parent's Signature _____ Date _____

# Canon-McMillan School District – Allergy Action Plan

Place Child's Picture Here

Student's Name: _____ D.O.B.: _____ Teacher: _____

**ALLERGY TO:** _____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

## ♦ STEP 1: TREATMENT ♦

| **Symptoms:** | | **Give Checked Medication**:** **(To be determined by physician authorizing treatment) | |
|---|---|---|---|
| ■ If a food allergen has been ingested, but *no symptoms*: | | ☐ Epinephrine | ☐ Antihistamine |
| ■ Mouth | Itching, tingling, or swelling of lips, tongue, mouth | ☐ Epinephrine | ☐ Antihistamine |
| ■ Skin | Hives, itchy rash, swelling of the face or extremities | ☐ Epinephrine | ☐ Antihistamine |
| ■ Gut | Nausea, abdominal cramps, vomiting, diarrhea | ☐ Epinephrine | ☐ Antihistamine |
| ■ Throat † | Tightening of throat, hoarseness, hacking cough | ☐ Epinephrine | ☐ Antihistamine |
| ■ Lung † | Shortness of breath, repetitive coughing, wheezing | ☐ Epinephrine | ☐ Antihistamine |
| ■ Heart † | Weak or thready pulse, low blood pressure, fainting, pale, blueness | ☐ Epinephrine | ☐ Antihistamine |
| ■ Other † | _____ | ☐ Epinephrine | ☐ Antihistamine |
| ■ If reaction is progressing (several of the above areas affected), give: | | ☐ Epinephrine | ☐ Antihistamine |

†Potentially life-threatening. The severity of symptoms can quickly change.

## DOSAGE

**Epinephrine**: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg
(see reverse side for instructions)

**Antihistamine**: give _____
medication/dose/route

**Other**: give _____
medication/dose/route

**IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.**

## ♦ STEP 2: EMERGENCY CALLS ♦

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number: _____
3. Parent _____ Phone Number(s): _____
4. Emergency contacts:
   Name/Relationship Phone Number(s)

   a. _____ 1) _____ 2) _____

   b. _____ 1) _____ 2) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY:

Parent/Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____
(Required)

## TRAINED STAFF MEMBERS

1. _____ Room _____

2. _____ Room _____

3. _____ Room _____

### EpiPen® and EpiPen® Jr. Directions

- **Pull off gray activation cap.**

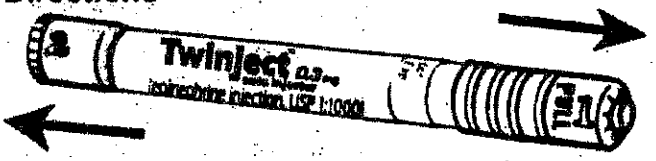



- **Hold black tip near outer thigh (always apply to thigh).**



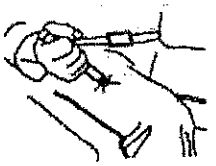
- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

### Twinject® 0.3 mg and Twinject® 0.15 mg Directions




- **Remove caps labeled "1" and "2."**

- **Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.**



**<u>SECOND DOSE ADMINISTRATION</u>:**
**If symptoms don't improve after 10 minutes, administer second dose:**

- **Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.**



- **Slide yellow collar off plunger.**

- **Put needle into thigh through skin, push plunger down all the way, and remove.**



**Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.**

**For children with multiple food allergies, consider providing separate Action Plans for different foods.**

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

The Food Allergy & Anaphylaxis Network

CANON-McMILLAN SCHOOL DISTRICT
200 Big Mac Boulevard
Canonsburg, PA 15317

# AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

(Prescription and Over the Counter)

DATE: _____ GRADE: _____

_____ must receive the following medication
*(Full Name of Pupil)*
during school hours in order to maintain sufficient health to participate in the school program. All medication must be in the original manufacturer's container or the pharmacy labeled bottle.

Name of Medication: _____

Prescribed Dosage: _____

Time Schedule: _____

Length of Time (days/weeks): _____

Reason for Administration: _____

Possible Side Effects: _____

Regarding asthma inhalers, the child (check only one) _____ is _____ is not able to self-administer the medication. If the student can self-administer, s/he has permission to carry the inhaler.

Regarding epi-pens, the child (check only one) _____ is _____is not permitted to carry the epi-pen with them.

I do hereby release, discharge, and hold harmless the Canon-McMillan School District, its agents and employees, from any and all liability and claims whatsoever arising from the administration of the above medication to my child/ward which I hereby expressly authorize.

_____ _____
*(Signature of Physician)* *(Signature of Parent/Guardian)*

*Revised 3/22/2023*

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200 Big Mac Boulevard
Canonsburg, PA 15317

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*Revised 3/22/2023*