

Effective School Year _____



BISMARCK PUBLIC SCHOOLS

Student Anaphylaxis Action Plan and Authorization for Epinephrine and Antihistamine

Form with fields: Child's Name, Parent(s)/Guardian(s), Parent/Guardian Phone Numbers (Home, Work, Cell), Emergency Contact (Other Than Parent/Guardian), Physician/Phone, Hospital/Phone, School/Teacher, DOB, Grade, Emergency Phone.

ALLERGY MANAGEMENT INFORMATION

1. This child is severely allergic to: Describe what happened when child was first diagnosed with allergy:

2. This child is allergic by the following ways of exposure (check all that apply): Direct contact (touching), Ingestion (if eaten), If bitten or stung, In the air (inhalation), Other/please explain:

3. Self-Care: a. Is this child able to monitor and prevent his/her own exposures? b. Does this child: Tell an adult immediately after an exposure? Wear a medical alert bracelet, necklace, or watchband? Tell peers and adults about the allergy? Know what foods to avoid? Ask about food ingredients? Read and understand food labels? Firmly refuse a problem food? c. Does this child have an emergency medication? d. Has this child ever self-administered their emergency medication? e. Will this child have an antihistamine at school?

4. Has epinephrine ever been administered to this child for this allergen? If "yes", explain: What symptoms were present? What was the response?

SCHOOL ACTION PLAN

- a. Retrieve epinephrine auto-injector which will be located here: _____
- b. Give medication as ordered on Health Care Provider Form 42a
- c. Follow Health Care Provider Form 42a
- d. Call **911** if epinephrine is given
- e. Call parent/guardian
- f. An adult trained in CPR is to stay with student—monitor and begin CPR if necessary
- g. After epinephrine administration, student may experience a rapid heart rate, anxiousness or develop a headache

PARENT CARE AUTHORIZATION

- I understand that school personnel will make good faith efforts to provide medical care to my child and acknowledge school personnel will not be held legally or financially responsible for this care.
- I will notify the school immediately of any changes in my child's health status or medication.
- I give permission to School personnel to contact my child's physician as needed; and that medication/health information may be shared with staff who need to know.
- If I don't provide the required "Healthcare Provider Anaphylaxis Action Plan," I give my consent for Bismarck Public Schools to obtain it from my child's healthcare provider.

Parent/Guardian Signature of Approval (*Required*): _____ Date: _____

EPINEPHRINE AND ANTIHISTAMINE AUTHORIZATION

Please bring this completed form along with your child's medication(s) to school. Medication must be in its original container with label attached – small containers preferred.

Inject into outer thigh (check one): EpiPen® EpiPen® Junior Auvi-Q® Adrenaclick®

Name of antihistamine: _____ Strength: _____ Dose: _____

Time to give at school: _____

Instruction for use: _____

Medication side effects: _____

Other information staff should know about student and these medications: _____

As parent/guardian of the above-named child, I give permission to Bismarck Public School personnel to administer the above-named medication(s) to my child as directed by my health care provider; I also acknowledge school personnel will not be held legally or financially responsible for the administration of this medication(s).

Parent/Guardian Signature of Approval (*Required*): _____ Date: _____