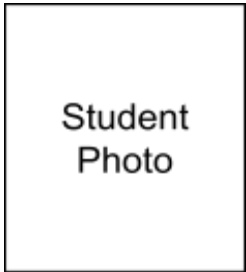




Fairbanks North Star Borough School District
Allergy/Anaphylaxis Action Plan



LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

MEDICAL PROVIDER AUTHORIZATION

BACKGROUND

Allergy/Anaphylaxis Trigger(s) - What is your student allergic to that triggers symptoms?

Does this student have asthma? **Having asthma increases the risk of having a more severe allergic reaction.* YES NO

Does this student have food allergies? **If yes, please complete the Meals and/or Accommodations form.* YES NO

STUDENT SYMPTOMS (Commonly observed symptoms listed; other symptoms may also require evaluation or treatment)

Mild Symptoms

Itchy Nose Itchy Mouth Sneezing A few hives Other _____

Severe Symptoms

SOB, wheezing, or coughing Cyanotic Weak pulse Faint or dizzy Tight or hoarse throat
 Vomiting or diarrhea, if severe Trouble swallowing Multiple hives Feeling of doom
 Pain or tightness in chest Unconsciousness Abdominal cramping or pain
 Swollen face, eyes, or tongue Altered mental status Other _____

MEDICATION ORDER

Is this student able to safely carry an epinephrine auto-injector or nasal spray during school hours? YES NO
(If this student is not able to self-treat, a nurse or trained adult may administer Epinephrine auto-injector or nasal spray)

Zytec, oral antihistamine per FNSBSD standing orders; use per package instructions for *Mild Symptoms* as indicated above.

epinephrine (**EPIPEN**®) 0.3 mg IM for *Severe Symptoms as indicated above.*

epinephrine (**EPIPEN Jr.**®) 0.15 mg IM for *Severe Symptoms as indicated above.*

epinephrine (**neffy**®) 2 mg NAS for *Severe Symptoms as indicated above.*

Other _____

ADDITIONAL COMMENTS

MEDICAL PROVIDER NAME/TITLE	PHONE NUMBER
MEDICAL PROVIDER SIGNATURE	DATE

THESE ORDERS EXPIRE AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL



Fairbanks North Star Borough School District
Allergy/Anaphylaxis Action Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
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PARENT/GUARDIAN AGREEMENT AND AUTHORIZATION

I request that the medication(s) selected and allergy/anaphylaxis protocols listed on this plan be provided to my child. ***I will provide needed medications or supplies for care in school. Prescription medication must be in the original pharmacy container labeled with the following information: student name, medication, dosage, route, administration time, ordering healthcare provider, pharmacy, date issued, and prescription number.*** I understand that, in the absence of Health Services personnel, other trained Fairbanks North Star Borough School District ("FNSBSD") personnel may administer this medication.

Employees and agents of the Fairbanks North Star Borough School District ("FNSBSD") strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless FNSBSD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify FNSBSD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and FNSBSD as part of the provision of my child's care. I agree for Health Services personnel to share health information with FNSBS staff on a need-to-know basis for my child's safety and to foster academic success. I understand that ANY remaining medication(s) will be disposed of at the end of the school year, unless I pick up the remaining medication(s) by the last school day, as indicated on the FNSBSD school year calendar.

THIS CARE PLAN EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL.

PARENT/GUARDIAN NAME	RELATIONSHIP TO STUDENT	PHONE NUMBER
PARENT/GUARDIAN SIGNATURE		DATE

STUDENT SELF-CARRY AGREEMENT

My student **SHOULD NOT** carry/self-administer his/her medication **YES**, my student **SHOULD** be allowed to carry/self-administer his/her medication

Complete this section **ONLY** if student may self-carry his/her medication - I have been trained in the use of my epinephrine auto-injector or nasal spray and allergy medication. I understand the signs and symptoms of an allergic reaction and agree to have my epinephrine auto-injector or nasal spray available at all times. I will notify a responsible adult (teacher, nurse, health assistant, coach, noon duty, etc.) **IMMEDIATELY** if I use my epinephrine auto-injector or nasal spray. I will not share my medication with other students or leave my medication unattended. I will use my allergy medication only for the prescribed purpose.

STUDENT NAME	
STUDENT SIGNATURE	DATE

NURSE PLAN REVIEW AND STAFF TRAINING

I have reviewed the Allergy/Anaphylaxis Care Plan for accuracy and ensure that all required fields and signatures are completed before administering medication to a student. I approve of the agreement arranged between the physician, parent, nurse, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME	
NURSE SIGNATURE	DATE

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