



Food/Insect Allergy Action Plan

Student's Name: _____ Date of Birth: _____ 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:		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Throat*	Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Lung*	Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Heart*	Thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Other*		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
If reaction is progressing (several of the above areas affected), give		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly _____
 Name of Medication

Antihistamine: _____
 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 (EMS: _____). State than an allergic reaction has been treated, and additional epinephrine may be needed.

2. 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.

I give Forsyth County School employees permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

I certify that this child has a medical history of allergy and has been trained in the use of epinephrine, and is judged by me to be:

_____ capable of carrying and self-administering the listed medication(s),

_____ **NOT** capable of carrying and self-administering the listed medication(s).

 Physician Name (PRINT) Physician Signature Date

 Parent Name (PRINT) Parent Signature Date

Reviewed by: _____ Date: _____

*Refer to 504 coordinator if appropriate



Request for Administration of Medication

Medications can be administered during school hours, if necessary, with this completed form for any over the counter (OTC) or prescription medications.

I understand that:

- All medications must be approved by the United States (US) Food and Drug Administration.
- **Prescription medications** must be from a US pharmacy in the original prescription labeled container, which states the student's name, date, name of licensed practitioner, name of the medication, medication strength, route and frequency of medication, instructions for use and name of pharmacy filling the prescription. A licensed practitioner's signature is required on this form within 10 school days of parent or guardian's request for administration. We recommend that you ask the pharmacy for three labeled prescription containers: one for home, one for the school clinic and one for field trips. Expired medication will not be administered.
- **Over the counter medications** must be distributed by a US manufacturer/lab and in the original container with an intact manufacturer's label. Only parent or guardian signature is needed on this form *unless* the medication request is for more than 10 consecutive school days and/or at the school's discretion. Expired medication will not be administered.
- All medication must be BROUGHT TO THE SCHOOL CLINIC BY PARENT/GUARDIAN. Students may not have medication in their possession, unless considered an emergency medication. Completion of this form, FCS Authorization to Carry Emergency Medication form and appropriate care plan is required in such circumstances.
- Parent/Guardian must provide the medication, related supplies, or equipment along with specific instructions for administration.
- It is the parent or guardian's responsibility to inform the school of any pertinent changes in their student's medication and/or health condition.
- The school nurse is not always available to assist in administering medication, and the student may be assisted by an FCS employee designated by the school administration.
- With the completion of this form, FCS employees may contact my child's health care provider and/or pharmacy to acquire clarification concerning this medication.
- Medications must be PICKED UP BY PARENT/GUARDIAN. Any medication not picked up from the school by the last school day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and an administrator.
- Any student possessing a prescription or OTC medication not in accordance with these guidelines will be considered in violation of FCS Board Policy JCDAC: Student Drug Use and shall be subject to the discipline set forth in FCS Code of Conduct.

Name of Student: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Medication Name: _____ Dose: _____

Route: _____ Time(s) of Administration: _____

Allergies: _____ Stop Medication on: _____

**I hereby give my permission for my child to receive this medication at school. I hereby release and discharge the Forsyth County Board of Education and its employees and officials from all liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication. I hereby release officials from any liability because of any injury or damage which might occur.*

Parent/Guardian Name (Print) _____ Parent/Guardian Signature _____ Date _____

Home Phone _____ Work Phone _____ Cell phone _____

To be completed by Licensed Practitioner (as required)

Condition/Illness Requiring Medication: _____

Possible Side Effects of Medication: _____

Other Medication Student is Taking: _____

Licensed Practitioner's Signature: _____ Date: _____

Licensed Practitioner's Name Printed: _____ Phone: _____

Parent/Guardian Picked Up Medication: _____ Date: _____

Parent Signature: _____ Nurse: _____ Date: _____



Request for Administration of Medication

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- **Prescription medications** must be from a US pharmacy in the original prescription labeled container, which states the student's name, date, name of licensed practitioner, name of the medication, medication strength, route and frequency of medication, instructions for use and name of pharmacy filling the prescription. A licensed practitioner's signature is required on this form within 10 school days of parent or guardian's request for administration. We recommend that you ask the pharmacy for three labeled prescription containers: one for home, one for the school clinic and one for field trips. Expired medication will not be administered.
- **Over the counter medications** must be distributed by a US manufacturer/lab and in the original container with an intact manufacturer's label. Only parent or guardian signature is needed on this form *unless* the medication request is for more than 10 consecutive school days and/or at the school's discretion. Expired medication will not be administered.
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- Parent/Guardian must provide the medication, related supplies, or equipment along with specific instructions for administration.
- It is the parent or guardian's responsibility to inform the school of any pertinent changes in their student's medication and/or health condition.
- The school nurse is not always available to assist in administering medication, and the student may be assisted by an FCS employee designated by the school administration.
- With the completion of this form, FCS employees may contact my child's health care provider and/or pharmacy to acquire clarification concerning this medication.
- Medications must be PICKED UP BY PARENT/GUARDIAN. Any medication not picked up from the school by the last school day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and an administrator.
- Any student possessing a prescription or OTC medication not in accordance with these guidelines will be considered in violation of FCS Board Policy JCDAC: Student Drug Use and shall be subject to the discipline set forth in FCS Code of Conduct.

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School: _____ Grade: _____ Teacher: _____

Medication Name: _____ Dose: _____

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Allergies: _____ Stop Medication on: _____

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Parent/Guardian Name (Print) _____ Parent/Guardian Signature _____ Date _____

Home Phone _____ Work Phone _____ Cell phone _____

To be completed by Licensed Practitioner (as required)

Condition/Illness Requiring Medication: _____

Possible Side Effects of Medication: _____

Other Medication Student is Taking: _____

Licensed Practitioner's Signature: _____ Date: _____

Licensed Practitioner's Name Printed: _____ Phone: _____

Parent/Guardian Picked Up Medication: _____ Date: _____

Parent Signature: _____ Nurse: _____ Date: _____



Authorization For Students to Carry a Prescription Inhaler, Epinephrine Auto Injector, Insulin, and Diabetic Supplies, or Other Approved Medication

_____ needs to carry the following prescription labeled inhaler, epinephrine auto injector, insulin, and diabetic supplies, and/or

_____ prescription medication with him/her. The above-named student has been instructed in the proper use of the medication and fully understands how to administer this medication.

It is preferable that a second prescription inhaler, epinephrine auto injector, additional insulin, and diabetic supplies or other prescribed medication be kept in the school in case the first is lost or left at home.

Name of Medication: _____

Practice Name Address Telephone Number

Examiner's Name (Please Print) Credentials

Examiner's Signature Date

I have been instructed in the proper use of my prescription labeled medication and fully understand how it is administered. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept responsibility for notifying the school nurse each time I take my medication.

Student's Signature Date

I hereby request that the above-named student, over whom I have legal guardianship, be allowed to carry, and use this prescribed medication at school:

- I accept legal responsibility should the medication be lost, given to, or taken by another person other than the above-named student.
- I understand that if this should happen, the privilege of carrying the medication may be altered.
- I release Forsyth County School System and its employees of any legal responsibility when the above-named student administers his/her own medication.

Parent/Guardian Name (Please Print) Parent/Guardian Signature Date



Food Allergy Action Plan – Parent Questionnaire

Student: _____ Date of Birth: _____

Mother/Guardian: _____ Phone #1: _____ Phone #2: _____

Father/Guardian: _____ Phone #1: _____ Phone #2: _____

Allergy: _____

Food Allergy Accommodations

- Foods and alternative snacks will be approved or provided by parent/guardian.
- Parent/guardian should be notified of any planned parties as early as possible.
- Classroom projects should be reviewed by the teaching staff to avoid specified allergens.
- Student is responsible for making his/her own food decisions. Yes No
- When eating, request student eats in a specific area. Yes No
 - Where? _____
- No restrictions
- Other (specify)

Bus Concerns – Transportation should be alerted to student’s allergy.

- This student carries Epi auto-injector on the bus? Yes No
- Epi auto-injector can be found in Backpack Waist pack On Person
Other (specify): _____
- Student will sit at front of the bus. Yes No
- Other (specify): _____

Field Trip Procedures – Epi auto-injector must accompany student during any off-campus activities.

- The student must remain with the teacher or parent/guardian during the entire field trip? Yes No
- Staff members on trip must be trained regarding Epi auto-injector use and this health care plan (plan must be taken).
- Other (specify): _____

ADDITIONAL EMERGENCY CONTACTS

- Name: _____ Relationship: _____ Phone: _____
- Name: _____ Relationship: _____ Phone: _____

- I request this medication to be given as ordered by the licensed health professional (LHP) (i.e., doctor, nurse practitioner, PAC).
- I give health services staff permission to communicate with the LHP/medical office staff about this plan and medication.
- I understand that any medication will not necessarily be given by a school nurse but may be given by trained and supervised school staff.
- I release school staff from any liability in the administration of this medication at school.
- Medical/medication information may be shared with school staff working with my child and 911 staff if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the LHP. Student is encouraged to wear a medical ID bracelet identifying the medical condition.
- I request and authorize my child to carry and/or self-administer their medication. Yes No
- Students who misuse or abuse medications may be subject to violating the Code of Conduct.

Parent/Guardian Print Name _____ Signature _____ Date _____

Device(s) if any: _____ Expiration date(s): _____

School Nurse Print Name _____ Signature _____ Date _____

A meeting will be scheduled with parent(s)/ guardian(s) and school staff.



Insect Allergy Action Plan – Parent Questionnaire

Student: _____ **Date of Birth:** _____

Mother/Guardian: _____ **Phone #1:** _____ **Phone #2:** _____

Father/Guardian: _____ **Phone #1:** _____ **Phone #2:** _____

Allergy: _____

Insect Allergy Accommodations

- No restrictions
- Other (specify) _____

Bus Concerns – Transportation should be alerted to student’s allergy.

- This student carries Epi auto-injector on the bus? Yes No
- Epi auto-injector can be found in Backpack Waist pack On Person
Other (specify): _____
- Student will sit at front of the bus. Yes No
- Other (specify): _____

Field Trip Procedures – Epi auto-injector must accompany student during any off-campus activities.

- The student must remain with the teacher or parent/guardian during the entire field trip? Yes No
- Staff members on trip must be trained regarding Epi auto-injector use and this health care plan (plan must be taken).
- Other (specify): _____

ADDITIONAL EMERGENCY CONTACTS

3. Name: _____ Relationship: _____ Phone: _____

4. Name: _____ Relationship: _____ Phone: _____

- I request this medication to be given as ordered by the licensed health professional (LHP) (i.e., doctor, nurse practitioner, PAC).
- I give health services staff permission to communicate with the LHP/medical office staff about this plan and medication.
- I understand that any medication will not necessarily be given by a school nurse but may be given by trained and supervised school staff.
- I release school staff from any liability in the administration of this medication at school.
- Medical/medication information may be shared with school staff working with my child and 911 staff if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the LHP. Student is encouraged to wear a medical ID bracelet identifying the medical condition.
- I request and authorize my child to carry and/or self-administer their medication. Yes No
- Students who misuse or abuse medications may be subject to violating the Code of Conduct.

Parent/Guardian Print Name _____ **Signature** _____ **Date** _____

Device(s) if any: _____ Expiration date(s): _____

School Nurse Print Name _____ **Signature** _____ **Date** _____

A meeting will be scheduled with parent(s)/ guardian(s) and school staff.